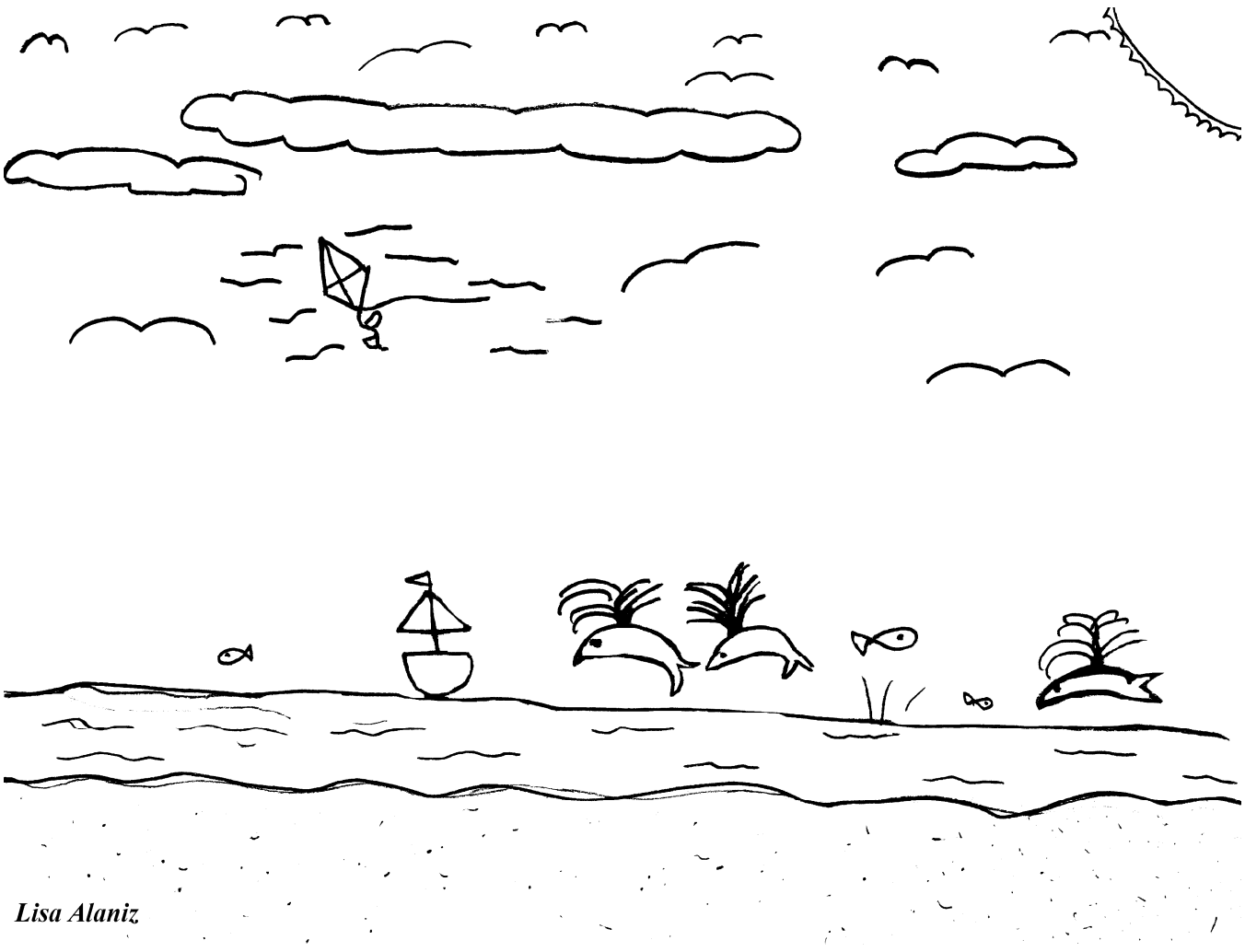
TEXAS REGISTER

Volume 33 Number 29 *July 18, 2008* *Pages 5625 - 5818*



Lisa Alaniz

School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

***Texas Register,* (ISSN 0362-4781, USPS 120-090),** is published weekly (52 times per year) for $211.00 ($311.00 for first class mail delivery) by LexisNexis Matthew Bender & Co., Inc., 1275 Broadway, Albany, N.Y. 12204-2694.

The ***Texas Register*** is published under the Government Code, Title 10, Chapter 2002. Periodicals Postage Paid at Albany, N.Y. and at additional mailing offices.

POSTMASTER: Send address changes to the ***Texas Register,*** 136 Carlin Rd., Conklin, N.Y. 13748-1531.

a section of the
Office of the Secretary of State
P.O. Box 13824
Austin, TX 78711-3824
(512) 463-5561
FAX (512) 463-5569
http://www.sos.state.tx.us
register@sos.state.tx.us

IN THIS ISSUE

THE ATTORNEY GENERAL

The *Texas Register* publishes summaries of the following: Requests for Opinions, Opinions, Open Records Decisions.

An index to the full text of these documents is available from the Attorney General's Internet site http://www.oag.state.tx.us. Telephone: 512-936-1730. For information about pending requests for opinions, telephone 512-463-2110.

An Attorney General Opinion is a written interpretation of existing law. The Attorney General writes opinions as part of his responsibility to act as legal counsel for the State of Texas. Opinions are written only at the request of certain state officials. The Texas Government Code indicates to whom the Attorney General may provide a legal opinion. He may not write legal opinions for private individuals or for any officials other than those specified by statute. (Listing of authorized requestors: http://www.oag.state.tx.us/opinopen/opinhome.shtml.)

Request for Opinions

RQ-0722-GA

Requestor:

Mr. Adan Munoz, Jr.

Executive Director

Texas Commission on Jail Standards

Post Office Box 12985

Austin, Texas 78711-2985

Whether a bailiff may supervise an inmate who is temporarily incarcerated in a courthouse holding cell (RQ-0722-GA)

Briefs requested by August 7, 2008

RQ-0723-GA

Requestor:

The Honorable D. Matt Bingham

Smith County Criminal District Attorney

Smith County Courthouse

100 North Broadway, 4th Floor

Tyler, Texas 75702

Re: Whether a state judge is authorized to permit felony and misdemeanor probationers to travel temporarily outside the state or to reside outside the state (RQ-0723-GA)

Briefs requested by August 8, 2008

RQ-0724-GA

Requestor:

The Honorable Jeff Wentworth

Chair, Committee on Jurisprudence

Texas State Senate

Post Office Box 12068

Austin, Texas 78711

Re: Whether the police chief of an independent school district may simultaneously serve as a member of a city council that is located within the geographical boundaries of the school district (RQ-0724-GA)

Briefs requested by August 11, 2008

For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.

TRD-200803512
Stacey Napier
Deputy Attorney General
Office of the Attorney General
Filed: July 9, 2008

♦ ♦ ♦

Opinions

Opinion No. GA-0640

The Honorable Kim Brimer

Chair, Committee on Administration

Texas State Senate

Post Office Box 12068

Austin, Texas 78701-1494

Re: Applicability of chapter 1501, Texas Insurance Code, to certain health benefit "cafeteria" plans offered by employers (RQ-0662-GA)

S U M M A R Y

The payment of individual health benefit plan premiums through a cafeteria plan that is funded entirely by pre-tax deductions from employer-paid salaries and that is not offered or endorsed by the employer is a small or large employer health benefit plan under section 1501.003(3) or 1501.004(3), Insurance Code, if the plan (1) is a health benefit plan that provides health care benefits (2) to the requisite employees and (3) is an employee welfare benefit plan under 29 C.F.R. section 2510.3-1(j) (i.e., does not fall within the safe harbor exclusion). Whether any particular plan meets these requirements involves questions of fact.

An individual who is eligible to participate in a cafeteria plan that is funded entirely by pre-tax deductions from employer-paid salaries and that constitutes a small or large employer health benefit plan under chapter 1501, may, depending upon the facts, be ineligible to participate in the Texas Health Insurance Risk Pool under chapter 1506 of the Insurance Code.

Opinion No. GA-0641

Mr. Robert Scott

Commissioner of Education

Texas Education Agency

1701 North Congress Avenue

Austin, Texas 78701-1494

Re: Proper formula under section 21.402, Education Code, for determining the required contributions by a school district to the Teacher Retirement System for compensation that exceeds the statutory minimum (RQ-0663-GA)

S U M M A R Y

The Seventy-ninth Legislature enacted legislation providing certain education personnel a salary increase. Section 825.405, Government Code, requires a school district to pay to the Teacher Retirement System a contribution for certain employees who receive more than the statutory minimum salary. The formula used to determine the statutory minimum salary includes the "salary provided by Section 21.402" of the Education Code. TEX. GOV'T CODE ANN. §825.405(b) (Vernon 2004); TEX. EDUC. CODE ANN. §21.402 (Vernon Supp. 2007). The salary provided by section 21.402 does not include the salary increase originally established by section 21.402(c-1) and arguably perpetuated by section 21.402(d).

For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.

TRD-200803511
Stacey Napier
Deputy Attorney General
Office of the Attorney General
Filed: July 9, 2008

♦ ♦ ♦

PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

TITLE 10. COMMUNITY DEVELOPMENT

PART 6. OFFICE OF RURAL COMMUNITY AFFAIRS

CHAPTER 255. TEXAS COMMUNITY DEVELOPMENT PROGRAM

SUBCHAPTER A. ALLOCATION OF PROGRAM FUNDS

10 TAC §§255.1, 255.2, 255.4, 255.9, 255.11, 255.16

The Office of Rural Community Affairs (Office) proposes amendments to §§255.1, 255.2, 255.4, 255.9, 255.11 and 255.16 for the Community Development Block Grant (CDBG) non-entitlement area funds.

The amendments are being proposed to specify criteria contained within the 2009 Action Plan.

Charles S. (Charlie) Stone, Executive Director of the Office, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections as proposed.

Mr. Stone has also determined that for each year of the first five-year period the sections are in effect the public benefit as a result of enforcing the sections will be the equitable allocation of CDBG non-entitlement are funds to eligible units of general local government in Texas. There will be no cost to small business or individuals.

Comments on the proposal may be submitted to Mark Wyatt, Director of Community Development, Office of Rural Community Affairs, P.O. Box 12877, Austin, Texas 78711, telephone: (512) 936-6701. Comments will be accepted for 30 days following the date of publication of this proposal in the *Texas Register*.

The amendments are proposed under §487.052 of the Government Code, which provides the executive committee with the authority to adopt rules concerning the implementation of the Office's responsibilities.

No other code, article, or statute is affected by the proposed sections.

§255.1. General Provisions.

(a) - (f) (No change.)

(g) Appeals. An applicant for funding under the TxCDBG may appeal the disposition of its application in accordance with this subsection.

(1) - (3) (No change.)

(4) An applicant for a grant, loan, or award under a community development block grant program may appeal a decision of the state review committee by filing a compliant with the Board. The Board will hold a hearing on a complaint filed with the Board and render a decision.

(5) [~~(4)~~] Appeals not submitted in accordance with this subsection are dismissed and may not be refiled.

(h) Threshold requirements. An applicant must satisfy each of the following requirements in order to be eligible to apply for or to receive funding under the TxCDBG:

(1) - (5) (No change.)

(6) Submit any past due audit to the Office.

(A) A community with one year's delinquent audit may be eligible to submit an application for funding by the established application deadline, but may not receive a contract award if the audit continues to be delinquent on the date the state review committee meets to approve[~~review~~] funding recommendations for applications from fund categories scheduled for state review committee review. For applications from fund categories that are not reviewed by the state review committee, a community with one year's delinquent audit may be eligible to submit an application for funding by the established application deadline, but may not receive a contract award if the audit continues to be delinquent on the date that the state review committee [~~the executive director~~] approves funding recommendations. [~~, or in the case of funding recommendations over $300,000, on the date that the Executive Committee reviews the funding recommendations.~~] Applications for the colonia self-help center fund and the disaster relief/urgent need fund are exempt from this threshold.

(B) A community with two years of delinquent audits may not apply for additional funding and may not receive a funding recommendation. This applies to all funding categories under the Texas Community Development Program. The colonia self-help centers fund may be exempt from this threshold, since funds for the self-help centers fund is included in the program's state budget appropriation. Failure to meet the threshold will be reported to the Texas Department of Housing and Community Affairs for review and recommendation. The disaster relief fund may be exempt from this threshold, but failure to meet this threshold will be forwarded to the Board[~~Executive Committee~~] for review and consideration.

(7) - (8) (No change.)

(i) - (k) (No change.)

(l) Unobligated and recaptured funds. Deobligated funds, unobligated funds and program income generated by TCF projects shall be retained for expenditure in accordance with the Consolidated Plan. Program income derived from TCF projects will be used by the Office for eligible TxCDBG activities in accordance with the Consolidated Plan. Any deobligated funds, unobligated funds, program income, and

unused funds from the current year's allocation or from previous years' allocations derived from any TxCDBG Fund, including program income recovered from TCF local revolving loan funds, and any reallocated funds which HUD has recaptured from Small Cities may be redistributed among the established current program year fund categories, for otherwise eligible projects. The selection of eligible projects to receive such funds is approved by the Office Executive Director, or when applicable, approved by the Board [~~Office Executive Committee~~] or by the TDA on a priority needs basis with eligible disaster relief and urgent need projects as the highest priority; followed by, any awards necessary to resolve appeals under fund categories requiring publication of contract awards in the *Texas Register*, TCF projects, special needs projects, projects in colonias, housing activities, and other projects as determined by the Office Executive Director. Other purposes or initiatives may be established as a priority use of such funds within existing fund categories by the Board [~~Office Executive Committee~~]. Should the TxCDBG be required to make payments to HUD to cover any loan payments not made by any recipient of a TxCDBG Section 108 loan guarantee, it would first use any available deobligated funds.

(m) - (n) (No change.)

(o) State review committee. The committee shall consult with and advise the Office's executive director on the administration and enforcement policies of the TxCDBG; in consultation with the executive director and TxCDBG office staff, review and approve grant and loan applications and associated funding awards of eligible counties and municipalities and advise and [~~review funding recommendations for applicants under the community development fund, community development supplemental fund, and planning/capacity building fund and~~] assist the Office's executive director in the allocation of program funds to the applicants; review appeals and submit recommendations for the disposition of such appeals to the Office's executive director in accordance with the procedures described in subsection (g) of this section; and report committee actions concerning these tasks to the Office's executive director through the minutes of committee meetings and written reports prepared by Office staff on behalf of the committee.

(p) - (t) (No change.)

(u) Performance measures. Each applicant for TxCDBG funds and each city or county receiving a contract award shall provide applicable information requested in application guides, the grant contract, or the most recent edition of the TxCDBG project implementation manual that is required by the Office to report on Community Development Block Grant program performance measures promulgated by the Board [~~Executive Committee~~], the Texas Legislature, and the U.S. Department of Housing and Urban Development.

(v) - (aa) (No change.)

§255.2. Community Development Fund.

(a) - (c) (No change.)

(d) Selection procedures.

(1) - (5) (No change.)

(6) In consultation with the executive director and TxCDBG office staff, the state review committee reviews and approves grant and loan applications and associated funding awards of eligible counties and municipalities.

[~~(6) The funding recommendations of the state review committee are then provided to the executive director of the Office. If the state review committee recommendations differ from the funding recommendations of a regional review committee, the state review committee must provide the affected regional review committee with a written explanation of its determination. The regional review committee may then provide a response to the executive director of the Office. If there is not a consensus between a regional review committee and the state review committee, all review comments by all of the parties involved in the selection process will be forwarded to the executive director of the Office.~~]

(7) An applicant for a grant, loan, or award under a community development block grant program may appeal a decision of the state review committee by filing a complaint with the Board. The Board will hold a hearing on a complaint filed with the board and render a decision.

[~~(7) The executive director of the Office reviews the 2007 final recommendations for project awards and except for awards exceeding $300,000 announces the contract awards. Awards exceeding $300,000 are submitted to the Executive Committee for approval.~~]

(8) Upon announcement of the 2007 program year contract awards, the Office staff works with recipients to execute the contract agreements. While the award must be based on the information provided in the application, the Office may negotiate any element of the contract with the recipient as long as the contract amount is not increased and the level of benefits described in the application is not decreased. The level of benefits may be negotiated only when the project is partially funded with the remainder of the target allocation within a region.

[~~(9) When the 2008 program year TxCDBG allocation becomes available, the executive director of the Office reviews the 2008 program year final recommendations for project awards and except for awards exceeding $300,000 announces the contract awards. Awards exceeding $300,000 are submitted to the Executive Committee for approval.~~]

(9) [~~(10)~~] Upon announcement of the 2006 program year contract awards, the Office staff works with recipients to execute the contract agreements. While the award must be based on the information provided in the application, the Office may negotiate any element of the contract with the recipient as long as the contract amount is not increased and the level of benefits described in the application is not decreased. The level of benefits may be negotiated only when the project is partially funded with the remainder of the target allocation within a region.

(e) - (f) (No change.)

§255.4. Planning/Capacity Building Fund.

(a) - (b) (No change.)

(c) Selection procedures. Scoring and the recommended ranking of projects are done by Office staff with input from the regional review committees. The application and selection procedures consist of the following steps.

(1) - (6) (No change.)

(7) The Office staff submits the 2007 program year and 2008 program year funding recommendations to the state review committee. In consultation with the executive director and TxCDBG office staff, the state review committee reviews and approves grant applications and associated funding awards of eligible counties and municipalities. [~~The state review committee reviews the project rankings and provides funding recommendations to the executive director of the Office.~~]

[~~(8) The executive director of the Office reviews the 2007 program year funding recommendations and except for awards exceeding $300,000 announces the contract awards. Awards exceeding $300,000 are submitted to the Executive Committee for approval.~~]

(8) [~~(9)~~] Upon the announcement of the 2007 program year contract awards, the Office staff works with recipients to execute the contract agreements. The award is based on the information provided in the application and on the amount of funding proposed for each contract activity based on the matrix included in the most recent application guide for this fund.

[~~(10) When the 2008 program year TxCDBG allocation becomes available, the executive director of the Office reviews the 2008 program year funding recommendations and except for awards exceeding $300,000 announces the contract awards. Awards exceeding $300,000 are submitted to the Executive Committee for approval.~~]

(9) [~~(11)~~] Upon the announcement of the 2006 program year contract awards, the Office staff works with recipients to execute the contract agreements. The award is based on the information provided in the application and on the amount of funding proposed for each contract activity based on the matrix included in the most recent application guide for this fund.

(d) (No change.)

§255.9. Colonia Fund.

(a) - (d) (No change.)

(e) Selection procedures.

(1) - (4) (No change.)

(5) Following a final technical review, the Office staff presents the funding recommendations for the 2007 and 2008 colonia construction fund and the 2007 colonia planning fund to the executive director of the Office. In consultation with the executive director and TxCDBG staff, the state review committee reviews and approves grant applications and associated funding awards of eligible counties and municipalities.

[~~(6) The executive director of the Office reviews the 2007 final recommendations and except for awards exceeding $300,000 announces the contract awards. Awards exceeding $300,000 are submitted to the Executive Committee for approval.~~]

(6) [~~(7)~~] Upon announcement of the 2007 contract awards, the Office staff works with recipients to execute the contract agreements. While the award must be based on the information provided in the application, the Office may negotiate any element of the contract with the recipient as long as the contract amount is not increased and the level of benefits described in the application is not decreased. The level of benefits may be negotiated only when the project is partially funded.

[~~(8) When the 2008 program year TxCDBG allocation becomes available, the executive director of the Office reviews the 2008 program year colonia construction fund final recommendations for project awards and except for awards exceeding $300,000 announces the contract awards. Awards exceeding $300,000 are submitted to the Executive Committee for approval.~~]

(f) - (j) (No change.)

§255.11. Small Towns Environment Program Fund.

(a) - (e) (No change.)

(f) Selection procedures.

(1) - (3) (No change.)

(4) Following a final technical review, the Office staff makes funding recommendations to the executive director of the Office. In consultation with the executive director of the Office and TxCDBG office staff, the state review committee reviews and approves grant applications and associated funding awards of eligible counties and municipalities.

[~~(5) The executive director of the Office reviews the final recommendations and except for awards exceeding $300,000 announces the contract awards. Awards exceeding $300,000 are submitted to the Executive Committee for approval.~~]

(5) [~~(6)~~] Upon announcement of contract awards, the Office staff works with recipients to execute the contract agreements. While the award must be based on the information provided in the application, the Office may negotiate any element of the contract with the recipient as long as the contract amount is not increased and the level of benefits described in the application is not decreased. The level of benefits may be negotiated only when the project is partially funded.

(g) (No change.)

§255.16. Non-Border Colonia Fund.

(a) - (b) (No change.)

(c) Selection procedures.

(1) - (4) (No change.)

(5) Following a final technical review, the Office staff submits the 2007 program year and 2008 program year funding recommendations to the executive director of the Office. In consultation with the executive director and TxCDBG office staff, the state review committee reviews and approves grant applications and associated funding awards of eligible counties and municipalities.

[~~(6) The executive director of the Office reviews the 2007 program year funding recommendations for project awards and except for awards exceeding $300,000 announces the contract awards. Awards exceeding $300,000 are submitted to the Executive Committee for approval.~~]

(6) [~~(7)~~] Upon announcement of the 2007 program year contract awards, the Office staff works with recipients to execute the contract agreements. While the award must be based on the information provided in the application, the Office may negotiate any element of the contract with the recipient as long as the contract amount is not increased and the level of benefits described in the application is not decreased. The level of benefits may be negotiated only when the project is partially funded.

[~~(8) When the 2008 program year TxCDBG allocation becomes available, the executive director of the Office reviews the 2008 program year final recommendations for project awards and except for awards exceeding $300,000 announces the contract awards. Awards exceeding $300,000 are submitted to the Executive Committee for approval.~~]

(7) [~~(9)~~] Upon announcement of the 2008 program year contract awards, the Office staff works with recipients to execute the contract agreements. While the award must be based on the information provided in the application, the Office may negotiate any element of the contract with the recipient as long as the contract amount is not increased and the level of benefits described in the application is not decreased. The level of benefits may be negotiated only when the project is partially funded with the remainder of the target allocation within a region.

(d) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on July 7, 2008.

TRD-200803485
Charles S. (Charlie) Stone
Executive Director
Office of Rural Community Affairs
Earliest possible date of adoption: August 17, 2008
For further information, please call: (512) 936-7887

♦ ♦ ♦

TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 101. ASSESSMENT

SUBCHAPTER FF. COMMISSIONER'S RULES CONCERNING DIAGNOSTIC ASSESSMENT

19 TAC §101.6001

The Texas Education Agency (TEA) proposes new §101.6001, concerning the Texas middle school diagnostic reading assessment. The proposed new rule would implement the requirement of the Texas Education Code (TEC), §28.006(c-1), which requires each school district to administer at the beginning of the seventh grade a reading instrument to each student whose performance on the assessment instrument in reading in Grade 6 did not demonstrate reading proficiency.

In 1999, the 76th Texas Legislature enacted the Student Success Initiative, which established grade advancement requirements based on student performance on statewide assessments in reading and/or mathematics in Grades 3, 5, and 8. In 2007, the 80th Texas Legislature passed legislation that would address the academic performance differences of elementary students and students in Grades 6-8 on the state reading assessments. In addition, Grade 8 students were subject to the grade advancement requirements of the Student Success Initiative beginning with school year 2007-2008.

The 80th Texas Legislature, through HB 2237, provided for the statewide implementation of a reading assessment to be administered at the beginning of Grade 7 to students who did not demonstrate reading proficiency, as determined by the commissioner, on the Grade 6 state assessment in reading. The results of the assessment will provide diagnostic information that school districts can use to offer reading intervention to these students based on their specific needs. A school district shall provide additional reading instruction and intervention to each student in Grade 7 assessed under the proposed new rule, as appropriate to improve the student's reading skills in the relevant areas identified through the assessment instrument.

Proposed new 19 TAC §101.6001 would establish provisions for middle school diagnostic reading assessment, including designating the diagnostic reading instrument to be used for identified students and providing criteria for alternative diagnostic reading instruments.

To comply with the proposed new rule, school districts will administer the Texas Middle School Fluency Assessment and/or a TEA-approved alternate research-based, diagnostic reading instrument. A school district that chooses to administer an alternate diagnostic reading instrument would be required to request prior approval from the TEA by submitting an explanation of how the alternate instrument meets specified criteria along with appropriate evidence.

Sharon Jackson, Associate Commissioner for Standards and Programs, has determined that for the first five-year period the new section is in effect there will be no additional fiscal implications for state or local government as a result of enforcing or administering the new section. Local school districts that use the designated diagnostic reading instrument would incur no additional costs. A local school district that chooses to use a diagnostic reading assessment instead of or in addition to the state diagnostic reading instrument would have to purchase it with district funds. This could cause a district to incur local costs, which are unknown and cannot be determined.

Dr. Jackson has determined that for each year of the first five years the new section is in effect the public benefit anticipated as a result of enforcing the new section will be that districts will be provided with a diagnostic reading instrument that can be used to assess Grade 7 students who are struggling readers and provide results that can be used in a reading intervention program for these students. There is no anticipated economic cost to persons who are required to comply with the proposed new section.

There is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

The public comment period on the proposal begins July 18, 2008, and ends August 18, 2008. Comments on the proposal may be submitted to Cristina De La Fuente-Valadez, Policy Coordination Division, Texas Education Agency, 1701 North Congress Avenue, Austin, Texas 78701, (512) 475-1497. Comments may also be submitted electronically to *rules@tea.state.tx.us* or faxed to (512) 463-0028.

The new section is proposed under the Texas Education Code, §28.006(c-1), added by House Bill 2237, 80th Texas Legislature, 2007, which authorizes the commissioner to adopt a reading instrument to administer at the beginning of the seventh grade to each student whose performance on the assessment instrument in reading in grade six did not demonstrate reading proficiency.

The new section implements the Texas Education Code, §28.006(c-1) and §28.006(g-1).

§101.6001. Texas Middle School Diagnostic Reading Assessment.

(a) Each school district shall administer during the first six weeks of the school year the diagnostic reading instrument specified in subsection (c) of this section to each student in Grade 7 whose performance on the Grade 6 Texas Assessment of Knowledge and Skills (TAKS) or TAKS-Accommodated in reading did not meet the passing standard. The admission, review, and dismissal committee for each student who was administered the TAKS-Modified in reading may determine if the diagnostic assessment is appropriate for use with that student.

(b) A student in Grade 7 who does not have a score for the statewide reading assessment in Grade 6 may be given an equivalent comprehension assessment. If that student does not meet the passing standard, then the student must be administered the diagnostic reading assessment specified in subsection (c) of this section.

(c) A school district must use the Texas Middle School Fluency Assessment and/or an alternate diagnostic reading instrument approved by the Texas Education Agency (TEA). A district must submit to the TEA an alternate diagnostic reading instrument for approval if it meets the criteria in subsection (d) of this section.

(d) An alternate diagnostic reading instrument must:

(1) be based on published scientific research in reading;

(2) be age and grade-level appropriate, valid, and reliable;

(3) identify specific skill difficulties in word analysis, fluency, and comprehension; and

(4) assist the teacher in making individualized instructional decisions based on the assessment results.

(e) A school district shall provide additional reading instruction and intervention to each student in Grade 7 who did not meet the passing standard on the Grade 6 state assessment in reading as appropriate to improve the student's reading skills in the areas of need identified by the diagnostic reading assessment.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on July 1, 2008.

TRD-200803411
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Earliest possible date of adoption: August 17, 2008
For further information, please call: (512) 475-1497

♦ ♦ ♦

TITLE 22. EXAMINING BOARDS

PART 23. TEXAS REAL ESTATE COMMISSION

CHAPTER 535. GENERAL PROVISIONS
SUBCHAPTER R. REAL ESTATE INSPECTORS

22 TAC §535.208

The Texas Real Estate Commission (TREC) proposes an amendment to §535.208, Application for a License. The amendment is proposed to adopt by reference a revised Certificate of Insurance, Form REI 8-1, which includes revisions to the Certificate of Insurance form for inspectors to use in showing proof of liability insurance coverage to the Commission.

The proposed amendment modifies the Certificate of Insurance form in order to clarify the types of conduct for which coverage is required, to clarify that the aggregate limit is as specified in the policy, and to extend the time period within which insurers must notify TREC of canceled or non-renewed policies from 10 days to 30 days.

Devon V. Bijansky, Assistant General Counsel, has determined that for the first five-year period the amendment as proposed is in effect, there will be no fiscal implications for the state or for units of local government as a result of enforcing or administering the amendment. There is no anticipated impact on local or state employment as a result of implementing the amendment. There is an anticipated impact on small businesses or micro-businesses as a result of implementing the amendment. There is no anticipated economic cost to persons who are required to comply with the proposed amendment.

Ms. Bijansky has also determined that for each year of the first five years the amendment as proposed is in effect, the public benefit anticipated as a result of enforcing the sections will be greater clarity regarding the type of coverage that inspectors must carry and, therefore, increased availability of insurance coverage for inspectors. The increased time period for insurers to notify TREC of canceled or non-renewed policies reflects the current practices of insurers regarding the processing of policy renewals.

Comments on the proposed amendment may be submitted to Devon V. Bijansky, Assistant General Counsel, Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188.

The amendment is proposed under Texas Occupations Code, §1101.151, which authorizes the Texas Real Estate Commission to make and enforce all rules and regulations necessary for the performance of its duties and to establish standards of conduct and ethics for its licensees in keeping with the purpose and intent of the Act to insure compliance with the provisions of the Act.

The statutes affected by the proposed amendment are Texas Occupations Code, Chapter and 1102. No other statute, code, or article is affected by the proposed amendment.

§535.208. Application for a License.

(a) - (b) (No change.)

(c) The Texas Real Estate Commission adopts by reference the following forms approved by the commission. These forms are published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188:

(1) - (4) (No change.)

(5) Certificate of Insurance, Form REI 8-1[~~8-0~~].

(d) - (f) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803469
Devon V. Bijansky
Assistant General Counsel
Texas Real Estate Commission
Earliest possible date of adoption: August 17, 2008
For further information, please call: (512) 465-3900

♦ ♦ ♦

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 3. LIFE, ACCIDENT AND HEALTH INSURANCE AND ANNUITIES
SUBCHAPTER Y. STANDARDS FOR LONG-TERM CARE INSURANCE, NON-PARTNERSHIP AND PARTNERSHIP LONG-TERM CARE INSURANCE COVERAGE UNDER INDIVIDUAL AND GROUP POLICIES,

ANNUITY CONTRACTS, AND LIFE INSURANCE POLICIES THAT PROVIDE LONG-TERM CARE BENEFITS WITHIN THE POLICY

The Texas Department of Insurance proposes amendments to §§3.3801 - 3.3804, 3.3821, 3.3826, 3.3829, 3.3830, 3.3833, 3.3834, 3.3837 - 3.3839, 3.3842, 3.3844, and 3.3846, and new §§3.3848, 3.3849, 3.3860, and 3.3870 - 3.3874, concerning standards for long-term care non-partnership insurance coverage, long-term care partnership insurance coverage under individual and group policies, annuity contracts, and life insurance policies that provide long-term care benefits within the policy or by rider. The proposed amendments and new sections are necessary to implement the insurance related provisions of Senate Bill (SB) 22, as enacted by the 80th Legislature, Regular Session, effective March 1, 2008. SB 22 establishes a state partnership for long-term care program in Texas that is intended to promote consumers' purchase of long-term care insurance from insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased coverage. In enacting SB 22, the Legislature found that long-term care is currently one of the leading cost drivers in the Medicaid program. (TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Enrolled), SB 22, 80th Legislature, Regular Session (October 18, 2007)). Further legislative findings indicate several other relevant factors. Although Medicaid pays for 67 percent of all nursing facility days in Texas, less than five percent of Texans have private long-term care insurance. As the population in Texas ages, the fiscal impact of publicly financing long-term care may lessen if more Texans purchase private long-term care insurance. However, prior to the enactment of SB 22, the law did not provide any incentive for Texans to purchase private long-term care insurance due to strict asset limits for Medicaid eligibility and required estate recovery of assets. In response, the Legislature enacted SB 22 to create a long-term care partnership program in Texas to provide the necessary incentive for Texans who can afford to purchase long-term care partnership insurance to do so. Texans who purchase long-term care partnership policies under the partnership program will be eligible for asset disregard equal to the long-term care insurance benefits that have been received to the date of Medicaid application from a partnership policy should they ever apply for Medicaid long-term care benefits. However, in order for a long-term care partnership insurance policy to be offered in Texas, a state plan amendment must meet the requirements of, and be approved under, the Deficit Reduction Act of 2005 (DRA) (Pub. L. No. 109-171). This proposal implements those provisions of SB 22 that establish the state partnership program that is to be administered, implemented, and monitored by the Texas Health and Human Services Commission (HHSC) with assistance from the Texas Department of Insurance. SB 22 adds new Subchapter C to Chapter 1651 of the Insurance Code relating to the Partnership for Long-Term Care Program. The amendments and new sections of Subchapter Y are proposed to implement new Subchapter C of Chapter 1651.

In addition to amending Chapter 1651 of the Insurance Code, SB 22 also amends Chapter 32 of the Human Resources Code to add new Subchapter C, relating to the Partnership for Long-Term Care Program. Section 32.102 of the Human Resources Code requires that the Partnership for Long-Term Care Program must be consistent with provisions governing the expansion of a state long-term partnership program established under the federal Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171. Under the DRA, a Qualified State Long-Term Care Insurance Partnership Program (Qualified Partnership) means an approved state plan amendment filed by the State Medicaid Director with the U.S. Department of Health and Human Services that provides an exemption from estate recovery in an amount equal to the benefits paid under partnership policies, where those benefits were disregarded in determining an individual's Medicaid eligibility. Under the Qualified Partnership, individuals who purchase partnership policies can apply for Medicaid under special HHSC rules for determining financial eligibility and estate recovery. These special rules generally allow the individual to protect assets equal to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries. This feature of the Qualified Partnership is known as "asset disregard" and the asset disregard applies to all insurance benefits received from a partnership policy. The asset disregard applies to all insurance benefits paid on a reimbursement, cash benefit basis, indemnity insurance basis, or on a "per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate" (within the meaning of §7702B(b)(2)(A) of the Internal Revenue Code). Similarly, the asset disregard applies to all insurance benefits received from a partnership policy regardless of whether such insurance benefits are for costs for long-term care that would be covered by Medicaid. The asset disregard as of any date equals the insurance benefits that have been received to that date from a partnership policy, even if additional benefits may be received in the future from a partnership policy. The asset disregard does not include the return of premium payments made upon the termination of a partnership policy (due to cancellation or death) since such payments do not represent insurance benefits.

Minimum Standards for a Long-Term Care Partnership Benefit Plan. With respect to the insurance related aspects of the Partnership for Long-Term Care Program, new §1651.104 of the Insurance Code requires the Commissioner, in consultation with the HHSC, to adopt minimum standards for a long-term care benefit plan that may qualify as an approved plan under the partnership for long-term care program. New §1651.104 also requires that the standards be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. A partnership policy is a long-term care insurance policy that satisfies all of the insurance related requirements of the DRA. The requirements of the DRA that a partnership policy must satisfy relate to federal tax law qualification, issue date, state of residence, compliance with DRA consumer requirements, inflation protection, and agent training requirements. These requirements are more fully explained in the following paragraphs.

Qualified under Federal Tax Law. Pursuant to §1917(b)(1)(C)(iii)(II) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(II)), a partnership policy must be a qualified long-term care insurance contract, as defined in §7702b(b) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)) issued not earlier than the effective date of the state plan amendment.

Issue Date. Pursuant to §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)), a partnership policy must not

be issued earlier than the effective date of the Qualified Partnership. The issue date is the effective date of coverage under the partnership policy. Thus, for example, in the case of a certificate issued under a group insurance contract, the effective date of coverage with respect to such certificate is the issue date of the certificate. Pursuant to §1917(b)(1)(C)(iii)(VII) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VII)) a policy received in an exchange of an existing non-partnership policy or certificate for a partnership policy or certificate after the effective date of the Qualified Partnership is treated as newly issued and thus is eligible for partnership policy status.

State of Residence. Pursuant to §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)), a partnership policy must cover an insured who was a resident of the State when coverage first became effective under the policy. In the case of an exchange of an existing non-partnership policy or certificate for a partnership policy or certificate, this state of residence requirement is applied based on the coverage date of the first long-term care insurance policy that was exchanged (State Medicaid Director's Letter (SMDL #06-019) July 27, 2006, issued by CMS, Supplement 8c to Attachment 2.6-A page 2 paragraph 2).

Consumer Protection Requirements. A partnership policy must meet all of the Federal consumer protection requirements specified in the DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)).

Inflation Protection. Pursuant to §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)), a partnership policy must include at least one of the following levels of inflation protection: (i) if the policy is sold to an individual who has not attained age 61 as of the date of purchase, the policy must provide compound annual inflation protection; (ii) if the policy is sold to an individual who has attained age 61 but has not attained age 76 as of the date of purchase, the policy must provide some level of inflation protection; and (iii) if the policy is sold to an individual who has attained age 76 as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection.

Agent Training Requirements. Additionally, pursuant to §1917(b)(1)(C)(iii)(V) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(V)), each individual who sells a long-term care partnership policy must complete training and demonstrate evidence of understanding partnership policies and how they relate to other public and private coverage of long-term care. Insurers that offer partnership policies shall certify to the Commissioner that each individual who sells partnership policies for the insurer has complied with the agent training requirements. The Department's proposed rules regulating long-term care partnership certification and continuing education course and licensee requirements were published in the March 21, 2008, edition of the *Texas Register* (33 TexReg 2512).

The following is a section-by-section overview of the proposal.

§3.3802. Purpose. The proposed amendments to §3.3802 divide the existing section into six paragraphs and add new paragraph (7) to state the new purpose relating to the long-term care partnership program. Proposed paragraph (7) provides that the new purpose is to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care partnership benefit plan as required in SB 22, codified as §1651.104 of the Insurance Code.

§3.3803. Applicability and Severability. The proposed amendments to §3.3803 amend the title of the section to remove the word "Scope" and add the word "Severability." This is necessary because §3.3850 (pertaining to Severability) is being repealed and the severability provisions are being relocated without change to §3.3803(b). The proposed new subsection (a)(1) specifies that §§3.3801 - 3.3804 (relating to General Provisions) apply to all long-term care insurance coverage that is regulated under Subchapter Y of Chapter 3. The introductory paragraph to existing §3.3803 is proposed to be redesignated as subsection (a)(2). The proposed amendments to the newly designated subsection (a)(2) specify that §§3.3805 - 3.3849 (relating to Non-partnership and Partnership Long-Term Care Insurance) apply to non-partnership and partnership long-term care benefit plans as defined in the Insurance Code §1651.003 and §3.3804 of this subchapter (relating to Definitions) and long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates delivered or issued for delivery in this state, except as specified in §3.3803(a)(5). Additionally, proposed new subsection (a)(3) specifies that §3.3860 (relating to Policy Summary Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts That Provide Long-Term Care Benefits) applies only to non-partnership life insurance policies that provide long-term care benefits by rider, except as specified in §3.3803(a)(5). Proposed new §3.3803(a)(4) specifies that §§3.3870 - 3.3874 of this subchapter (relating to Partnership Long-Term Care Insurance Only) apply only to long-term care partnership benefit plans as that term is defined in the Insurance Code §1651.101 and §1651.104 except as specified in §3.3803(a)(5). The existing provisions in §3.3803(1) and (2), relating to policies and certificates that are not subject to the requirements of the subchapter, are proposed to be re-designated as §3.3803(a)(5)(A) and (B). Additionally, the existing provision in §3.3803(2), which is proposed to be re-designated as §3.3803(a)(5)(B), is proposed to be amended to clarify that certificates as well as policies that are not designed, advertised, marketed, or offered as long-term care or nursing home insurance are not subject to regulation under the subchapter. These proposed amendments to §3.3803 are necessary to clarify the different types of policies and certificates that are being regulated under Subchapter Y and to specify which specific provisions in Subchapter Y apply to the various types of policies and certificates being regulated for purposes of clarity, implementation, and compliance. The proposed amendments to §3.3803 also add new subsection (b) to relocate without change the existing §3.3850 severability provisions that are being repealed, and the proposed repeal is also published in this edition of the *Texas Register.*

§3.3804. Definitions. The proposed amendments to §3.3804 add new paragraph (19) to include a definition of "long-term care benefit plan," a term that is used frequently throughout the subchapter. This definition is consistent with the definition in §1651.003 of the Insurance Code. Additionally, amendments are proposed to existing §3.3804(19), which is also proposed to be re-designated as paragraph (20), to amend the term

"long-term care insurance contract" to conform the term to the NAIC definition of "long-term care insurance." The proposed amendments to existing §3.3804(19) change the term from "long-term care insurance contract" to "long-term care insurance" as that term is defined by the NAIC because most of the existing and proposed regulations in Subchapter Y are based on the NAIC Model Regulations and Model Act. Because the term "long-term care insurance" is used throughout Subchapter Y, it is imperative that the definition of long-term care insurance in Subchapter Y conform with the NAIC definition. Subchapter Y is consistent with the NAIC definition which specifies that "the term includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance." To conform the proposed §3.3804(20) definition of "long-term care insurance" to the NAIC definition, the following requirements are proposed to be added: (i) the term includes a policy, certificate, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity; and (ii) long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; and health maintenance organizations to the extent they are authorized to issue life or health insurance. Additionally, an amendment is proposed to specify that the term long-term care insurance does not include life insurance policies that accelerate death benefits for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for benefits is conditioned upon the receipt of long-term care. The proposed amendments to §3.3804 add new paragraph (21) to include a definition of "long-term care insurance partnership contract." This definition defines the term to mean a long-term care insurance contract established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171 and the Insurance Code Chapter 1651 Subchapter C. This proposed new definition is necessary to clarify what constitutes a long-term care partnership insurance contract under the proposed amendments to Subchapter Y in this proposal and because these amendments are proposed to implement the requirement in SB 22 that the Commissioner, in consultation with the Health and Human Services Commission, adopt minimum standards for a long-term care benefit plan that will qualify as an approved plan under the partnership for long-term care program. In addition, paragraphs (20) - (30) are proposed to be redesignated as paragraphs (22) - (32).

§3.3826. Limitations and Exclusions. The proposed amendments to §3.3826 add new paragraph (6) to subsection (a) to permit exclusions and limitations for expenses for services or items paid under another long-term care or health insurance policy. The proposed amendments to §3.3826 further add new subsection (b) to specify that with respect to this section the "state of policy issue" is the state in which the individual policy or certificate was originally issued; existing subsection (b), which is proposed to be redesignated as subsection (c), permits exclusions and limitations for payment for services provided outside the United States. However, as required by the DRA, the issuer of long-term care insurance policies and certificates being claimed against in a state other than where the policy or certificate was issued must cover those services that would be covered in the state of policy issue irrespective of any licensing, registration, or certification requirements for providers in the other state. The proposed amendments to §3.3826 that add new paragraph (6) and new subsection (b) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with provisions established under the DRA. The DRA requires a partnership policy to conform with specific consumer protection provisions of the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulations and Model Act. Section 6B of the NAIC model regulations permits exclusions and limitations for expenses for services or items paid under another long-term care or health insurance policy and permits exclusions and limitations for payment for services provided outside the United States. These two NAIC provisions are reflected in proposed §3.3826(a)(6), §3.3826(b), and §3.3826(c), respectively.

§3.3829. Required Disclosures. The proposed amendments to §3.3829(b)(2) specify the two disclosure forms that must be provided to an applicant at the time of application or enrollment, or if the method of application does not allow for delivery at that time, the information must be provided at the time of delivery of the policy or certificate. The two disclosure forms are Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form. Proposed amendments to §3.3829(b)(8) specify the requirements and procedures that apply to the two disclosure forms, including text size and content, recommended format, and filing and approval procedures as applicable. A representation of proposed Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet is specified in new subsection (b)(8)(H). A representation of proposed Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form is specified in new subsection (b)(8)(I). Proposed new Form Number LHL560(LTC) Long-Term Care Personal Worksheet requires the insurer to obtain detailed information from the individual who is considering the purchase of a long-term care policy. Such information includes the applicant's current insurance and premium payments, the applicant's income and net worth, and also a disclosure of the insurer's rate history, and right to increase premiums. This form will assist the insurer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy. Proposed new Form Number LHL561(LTC) Long-Term Care Potential Rate Increase Disclosure Form requires the insurer to provide detailed information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policy options in the event of a rate increase. The proposed amendments to §3.3829 are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104 which requires that a partnership policy be consistent with provisions established under the DRA. The DRA requires a partnership policy to conform with specific consumer protection provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC consumer protection requirements for partnership policies include the provisions of §9 of the NAIC Long-Term Care Model Regulations, which pertain to Required Disclosures of Rating Practices to Consumers, and included in §9 is the requirement to use the new forms specified in §3.3829(b)(8)(H) and (I). These consumer protection provisions, which are required under the DRA, are necessary to require the use of these new forms in the marketing of long-term care policies. Additionally, based on input from the Office of Public Insurance Counsel (OPIC), consumer protection requirements

in the form of additional questions have been added to proposed Form Number LHL560(LTC) Long-Term Care Personal Worksheet. These questions are listed in the part of the form titled "Questions Related to Your Needs" and include questions to applicants regarding: (i) knowledge of what inabilities trigger long-term care benefits; (ii) awareness and meaning of the term "cognitive impairment;" (iii) understanding of policy limitations; and (iv) what type of long-term care service the applicant anticipates utilizing. These additional questions are included on the proposed Personal Worksheet form in order to more prominently disclose some of the most important limitations that are currently contained in long-term care policies.

§3.3830. Requirements for Application Forms and Replacement Coverage. The proposed amendment to §3.3830 adds new subsection (h). This new subsection requires that if a long-term care policy is being replaced by a life insurance policy with a long-term care rider that accelerates life insurance benefits to cover the cost of long-term care, the sale of the replacement policy must comply with all of the requirements of §3.3830. Additionally, if the policy being replaced is a life insurance policy, the insurer must comply with the replacement requirements of the Insurance Code Chapter 1114 (relating to Replacement of Certain Life Insurance Policies and Annuities), and Chapter 3 Subchapter NN (relating to Consumer Notices for Life Insurance Policy and Annuity Contract Replacements), and any additional rules adopted by the Department pursuant to the Insurance Code Chapter 1114. Further, if a life insurance policy with a long-term care rider that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer must comply with §3.3830, Chapter 3, Subchapter NN, and the Insurance Code Chapter 1114. This proposed amendment is necessary to implement the provisions of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §14 of the NAIC Long-Term Care Model Regulations relating to Requirements for Application Forms and Replacement Coverage. These §14 provisions are included in proposed new §3.3830(h).

§3.3837. Reporting Requirements. The proposed amendments to §3.3837 amend subsection (a) by adding new provisions to specify the requirements for insurers to report information to the Commissioner on a statewide basis regarding long-term care insurance policy or certificate replacements and lapses. Existing §3.3837(a) is proposed to be re-designated as subsection (a)(1)(A. The proposed amendments to §3.3837 divide existing subsection (a) into subsection (a)(1) relating to agent records; this is existing subsection (a); subsection (a)(2) relating to reporting of 10 percent of agents; this is existing subsection (a)(1) with proposed amendments; subsection (a)(3) relating to reporting the number of lapsed long-term care policies; this is existing subsection (a)(3) with proposed amendments; and subsection (a)(4) reporting number of replacement long-term care policies; this is existing subsection (a)(4) with proposed amendments. Existing §3.3837(a)(2) is proposed to be moved to new subsection (a)(1)(B) without changes; it provides that the purpose of the replacement and lapse reports is to review more closely agent activities regarding the sale of long-term care insurance and that reported replacement and lapse rates do not alone constitute a violation of insurance laws. Amendments to subsection (a)(2), pertaining to reporting of 10 percent of agents, are proposed to specify that each insurer shall report the information in accordance with the parts of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form concerning the 10 percent of the insurer's agents with the greatest percentages of policy or certificate lapses or replacements during the preceding calendar year and that insurers must submit the required information in an electronic format prescribed by the Department. Proposed Form Number LHL562(LTC) specifies the data elements that insurers will be required to report for such lapses and replacements. Specifically, each insurer must maintain records for each agent that is in the 10 percent of that insurer's agents with the greatest percentage of replacements and for each agent that is in the 10 percent of that insurer's agents with the greatest percentage of lapses. The proposed form requires information on each agent's name, number of policies sold by the agent, number of policies replaced and lapsed by the agent, and number of replacements and lapses as percent of number of policies sold by the agent. The proposed amendments to §3.3837 further amend subsection (a)(3) and (4) to require insurers to use the part of proposed Form Number LHL562(LTC) relating to Company Totals to comply with the reporting requirements in subsection (a)(3) and (4). The data that insurers are required to report under proposed subsection (a)(3) and (4) are insurance company totals for the number of lapsed and replacement long-term care policies sold as a percentage of its total number of long-term care policies in force as of the end of the preceding year. Under the proposed amendments to subsection (a)(3) and (4), the required information must be submitted electronically in a format prescribed by the Department. The proposed amendments to §3.3837(a)(1), (2), (3), and (4) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with the provisions established under the DRA. The DRA requires a partnership policy to conform with specific reporting requirement provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC reporting requirements for partnership policies include the provisions of §15 of the NAIC Long-Term Care Model Regulations, which pertain to Reporting Requirements. Section 15 requires insurers to use the new form specified in §3.3837(a)(2) to report the data specified in proposed amendments to subsection (a)(1), (2), (3), and (4). Existing §3.3837(a)(5) is proposed to be deleted because the requirement for reporting of the annual rate filings required under former Insurance Code Article 3.70-12 §4(b) (revised as Insurance Code §1651.053(c) as part of the non-substantive Insurance Code revision) is proposed to be moved to proposed new §3.3837(g) for purposes of organizational clarity.

The proposed amendments to §3.3837(b), pertaining to insurer reporting requirements relating to rescissions, are necessary to require the use of proposed Form Number LHL563(LTC) Rescission Reporting Form for Long-Term Care Policies specified in §3.3837(b) in lieu of existing form LTC RESCIND that is currently adopted by reference in §3.3848. The existing form is proposed to be included in §3.3837(b) with a new form number but without changes to the form requirements. The adoption by reference of the LTC RESCIND form in existing §3.3848 is proposed to be repealed, and the proposed repeal is also published in this edition

of the *Texas Register.* The proposed amendments to §3.3837(b) clarify that each insurer must report to the Commissioner, by no later than June 30 annually for the preceding calendar year, all rescissions of long-term care insurance policies or certificates except those rescissions voluntarily effectuated by an insured. The proposed new Form Number LHL563(LTC), consistent with existing form LTC RESCIND, requires each insurer to report for each rescission the policy form number, the policy and certificate number, the name of the insured, the date of the policy issuance, the date or dates that a claim or claims were submitted, the date of rescission, and a detailed reason for each rescission. Under the proposed amendments to §3.3837(b), the required information in proposed new Form Number LHL563(LTC) must be submitted electronically in a format prescribed by the Department. The proposed amendments to §3.3837(b), including the proposed new Form Number LHL563(LTC), are necessary to place all of the insurer reporting requirements in the subchapter in §3.3837. This will result in more efficient organization and greater clarity that will facilitate implementation, compliance, and enforcement of the rules.

The proposed amendments to §3.3837(c), pertaining to reporting requirements for claims denied by class of business, add new paragraph (1) to include the definitions of the terms "claim" and "denied" when those terms are used in the subsection. Amendments to subsection (c) are also proposed to require insurers to use proposed new Form Number LHL564(LTC) Long-Term Care Claim Denials Reporting Form, which is specified in §3.3837(c)(2), to comply with the reporting requirements in subsection (c)(2). Under the proposed amendments, each insurer is required to report 11 data elements for both state data and nationwide data for all long-term care insurance claim denials under in-force long-term care insurance policies, including total number of long-term care claims reported, total number of long-term care claims denied/not paid, number of claims not paid due to preexisting condition exclusion, and number of claims not paid due to waiting period not being met. The proposed amendments to §3.3837(c)(2) require the data in Form Number LHL564(LTC) to be submitted electronically in a format prescribed on the Department's website. The proposed amendments to §3.3837(c)(2) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §15 of the NAIC Long-Term Care Model Regulations, relating to Reporting Requirements. Section 15 contains the requirement that insurers must report state and nationwide data relating to claim denials in accordance with the proposed new form specified in §3.3837(c)(2).

The proposed amendments to §3.3837(d), pertaining to reporting requirements for the long-term care partnership program, delete the existing subsection (d) and propose new reporting requirements for all insurers that market partnership policies in Texas. Proposed new §3.3837(d) requires that each insurer report to the Department by June 30 of each year the information required in §32.107 of the Human Resources Code. Each insurer must specify the number of approved partnership plans sold in the state during the preceding calendar year and the average age of individuals purchasing approved partnership plans during the preceding calendar year. The information required in subsection (d) must be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in §3.3837(e). The required information includes reporting for two long-term care partnership policy types: comprehensive (institutional and community care) and nursing home (institutional only). Each insurer must submit the required information electronically in a format prescribed on the Department's website. SB 22 enacted new §32.107 of the Human Resources Code that requires the Texas Health and Human Services Commission (HHSC) to report this information in a biennial report to the Legislature by not later than September 30 of each even-numbered year. The purpose of the report is to provide information to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. The Department will report this data to the HHSC for use in fulfilling HHSC's requirements under §32.107 of the Human Resources Code. Existing §3.3837(d) specifies that the reporting requirements in §3.3837 relate only to long-term care insurance delivered or issued for delivery in this state; this provision is redundant of proposed new provisions in §3.3837 and is proposed to be deleted.

The proposed amendments to §3.3837, pertaining to reporting requirements for both partnership and non-partnership plans, add new subsection (e) to require that all insurers that market long-term care insurance in Texas report to the Department by June 30 of each year the number of non-partnership plans sold in the state during the preceding calendar year and the average age of individuals purchasing the non-partnership plans during the preceding calendar year. The information required in proposed new subsection (e) must be reported in accordance with Form Number LHL565(LTC) as specified in §3.3837(e). The required information includes reporting for four long-term care non-partnership policy types: comprehensive (institutional and community care); nursing home (institutional only); home health care (community-based services); and riders (attached to life policies or annuity contracts.) Each insurer must submit the required information electronically in a format prescribed on the Department's website. Proposed new §3.3837(e) is necessary to implement the provision of SB 22, codified as Human Resources Code §32.107. Section 32.107 requires that not later than September 30 of each even-numbered year the Texas Health and Human Services Commission (HHSC) shall submit a report to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. Therefore, the Department has determined that the most effective approach to measuring the progress of the partnership program in Texas is to compare partnership data as required pursuant to proposed §3.3837(d) and non-partnership data as required pursuant to proposed §3.3837(e). In order to provide a meaningful, comprehensive report on the progress of the partnership program to the Legislature, it is necessary that insurers report the non-partnership data specified in proposed new §3.3837(e) as well as the partnership data specified in the proposed amendments to §3.3837(d). The Department is au-

thorized to require non-partnership data from insurers under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Subchapter C of Chapter 1651 specifies the Department's regulatory functions with regard to the long-term care partnership program. While the Human Resources Code §32.107(a) requires the HHSC to submit the biennial report on the progress of the partnership program, any information that may be requested of the Department as provided in §32.107(b) of the Human Resources Code would have to be requested from insurers pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004.

Proposed new §3.3837(f) provides new suitability reporting requirements for all insurers that market long term care insurance policies in Texas. Insurers are required to provide suitability data on non-partnership and partnership policies sold in Texas in accordance with the requirements indicated in proposed new Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form as specified in §3.3837(f). The data is required to be reported to the Commissioner by no later than June 30 annually for the preceding calendar year. Under the proposed new requirements, insurers are required to report suitability data for long-term care partnership comprehensive (institutional and community care) and nursing home (institutional only) policies that includes total number of applications received, total number of applicants who declined to provide the personal worksheet information, total number of applicants who did not meet the suitability standards, and total number of applicants who chose to confirm after receiving a suitability letter. Proposed new §3.3837(f) requires insurers to report the same suitability data for long-term care non-partnership comprehensive, nursing home, and home health care policies, and riders attached to life policies and annuity contracts. The proposed reporting requirements require insurers to submit the data electronically in a format prescribed on the Department's website. Proposed new §3.3837(f) requirements for reporting suitability data for partnership policies sold in Texas are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §24 of the NAIC Long-Term Care Model Regulations, which pertain to Suitability. Section 24 contains the requirement that insurers must report the long-term care partnership data specified in proposed new §3.3837(f). Proposed new §3.3837(f) requirements for reporting suitability data are necessary for the Department to have an understanding of what is going on in terms of the marketing practices of those insurers that market partnership policies as well as those insurers that market non-partnership policies. The data will provide an essential tool in the Department's monitoring of whether long-term care policies are being sold appropriately, i.e., to those who actually need the coverage. The Department is authorized to require the non-partnership data from insurers under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including suitability as provided in §3.3842, which was adopted pursuant to §1651.004 of the Insurance Code for the purpose of implementing Chapter 1651.

Proposed new §3.3837(g) contains the requirement in existing §3.3837(a)(5) that requires insurers to file an annual rate filing required under former Insurance Code Article 3.70-12 §4(b) (revised as Insurance Code §1651.053(c) as part of the non-substantive Insurance Code revision) to demonstrate compliance with the applicable loss ratios of this state and any other filing requirement adopted by the Commissioner relating to loss ratios. The requirement applies to both partnership and non-partnership long-term care policies. Existing §3.3837(a)(5) is proposed to be redesignated as new §3.3837(g) and amended to clarify that the demonstration of compliance with applicable loss ratio standards that is in the current rule is in addition to any demonstration required under §§3.3831(c)(2)(B) - 3.3831(c)(2)(D) and that compliance with the statutory requirement includes providing the following information by calendar duration and separately by form number: (i) calendar duration; (ii) first year issued; (iii) actual earned premium by duration; (iv) actual incurred claims; (v) actual calendar duration loss ratio; (vi) anticipated calendar duration loss ratio; and (vii) number of insured lives. This also applies to partnership and non-partnership long-term care policies. The proposed requirements in re-designated §3.3837(g) are necessary to clarify the information a company must provide in order to demonstrate compliance with the Insurance Code §1651.053(c)(1).

§3.3838. Filing Requirements for Advertising. The proposed amendments to §3.3838(1) refine the requirements for the advertising of partnership and non-partnership long-term care insurance to exclude the necessity of filing institutional advertisements (as that term is defined in §21.102 of this title) if the advertisement only references long-term care insurance as a line of coverage. Institutional advertisements that provide details regarding the insurer's long-term care insurance products that go beyond merely identifying long-term care insurance as a line of coverage that is available from the insurer would continue to be subject to prior approval by the Commissioner, subject to the requirements in existing §3.3838. The proposed amendments to §3.3838(1) are necessary to exclude from the filing and review requirements long-term care insurance advertisements that do not provide any details on the long-term care insurance product. Because these advertisements are not currently a source of false, misleading, or deceptive marketing practices, the Department has determined that the Commissioner's review is not necessary. The result will be more efficient and cost-effective advertising filing requirements for long-term care insurers. Also, the reduction in the number of institutional advertisements that are filed with the Department for review will enable the Department to more effectively utilize Departmental resources without compromising consumer protection. The Department will be able to redirect its resources to advertising practices that are a more frequent source of false, misleading, or deceptive marketing practices. There are no changes proposed to existing §3.3838(2) and (3). The amendments to §3.3838(1), which apply to both partnership and non-partnership policies, are not required by SB 22 or any other state or federal legislation but rather are proposed pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

§3.3839. Standards for Marketing. Section 3.3839 specifies the marketing procedures that must be established and implemented by each insurer, health care service plan, or other entity marketing, either directly or through its agents, partnership or non-partnership long-term care insurance in this state. Proposed new §3.3839(a)(8), (9) and (10) mandate three new requirements: (i) each insurer or other entity marketing long-term care insurance in this state must, at the time of solicitation, provide written notice to the prospective policyholder that a senior insurance counseling program is available; (ii) each insurer or other entity must provide to the applicant at the time of application an explanation of the contingent nonforfeiture benefit upon lapse specified in §3.3844(g)(1), and if applicable, an explanation of the additional contingent nonforfeiture benefit upon lapse provided to policies with fixed or limited premium payment periods provided in §3.3844(g)(2); and (iii) each insurer or other entity must provide to the applicant, at the time of application, copies of the Long-Term Care Personal Worksheet as specified in §3.3829(b)(8)(H) and the Long-Term Care Potential Rate Increase Disclosure Form as specified in §3.3829(b)(8)(I). These new requirements are necessary to ensure that more consumers are better informed about the availability of the senior insurance counseling program and therefore, more consumers will participate in the counseling program. The Health Information Counseling and Advocacy Program of Texas is the senior counseling program and is operated by the Department. The program provides consumer information on long-term care insurance, including planning, insurance basics, need for such coverage, costs, and methods of financing. This information will mean that more consumers will be able to make more informed decisions regarding the purchase of long-term care insurance. Also, more consumers will be better informed about the contingent nonforfeiture benefit on lapse provisions, including the additional contingent nonforfeiture benefit upon lapse provided to policies with fixed or limited premium payment periods. A contingent nonforfeiture benefit upon lapse allows the insured to either choose a reduced benefit amount to prevent premium increases or to convert their policy to a paid-up status. The required information will explain the different contingent nonforfeiture benefit on lapse options that are available to a consumer if the consumer decides to allow their long-term care policy to lapse within 120 days of a substantial rate increase. With such information, more consumers will be aware of the possible range of benefits that they will have in the event that they are unwilling or unable to pay the long-term care premium in the face of a substantial rate increase by the insurer. This type of information will also assist consumers in making more informed decisions regarding the purchase of long-term care insurance.

As previously stated, the required use of these new forms, which is also required under proposed §3.3829, will provide additional information obtained from the applicant to assist the insurer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. Additionally, from the perspective of marketing standards, each agent marketing long-term care insurance will have information pertaining to each applicant or potential applicant that will enable the agent to identify those individuals who are financially suitable to purchase such insurance.

The proposed amendments to §3.3839 provide that the required notices in existing §3.3839(b)(1) and (2), relating to the existence or non-existence of inflation protection provisions in each policyholder's policy, are also marketing procedure requirements, along with the other marketing procedure requirements specified in §3.3839(a), that are subject to Department audit to verify compliance. These current notices, which are redesignated as §3.3839(a)(11)(A) and (B), respectively, must be provided to each policyholder who purchases a policy that contains inflation protection provisions and to each policyholder who purchases a policy that does not contain inflation protection provisions.

Existing §3.3839(b), which is proposed to be redesignated as §3.3839(a)(11), specifies the requirements for providing the required notices to policyholders. No changes are proposed to the existing required notices or to the existing requirements for providing the notice to policyholders. The proposed redesignation of existing §3.3839(b)(1) and (2) as §3.3839(a)(11)(A) and (B) is necessary to clarify that the required notices in existing §3.3839(b)(1) and (2) are also marketing procedure requirements, along with the other marketing procedure requirements specified in §3.3839(a), that are subject to Department audit to verify compliance. The proposed amendments to §3.3839, as applicable to partnership policies, are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. Section 23 contains the requirements specified in the proposed amendments to §3.3839. Section 23 A(5) requires each long-term care insurer to establish an auditable procedure for verifying compliance with all marketing procedures, including the required notices that are specified in redesignated §3.3839(a)(11)(A) and (B). In existing §3.3839 as currently structured, it is not clear that the inflation protection notice requirements in §3.3839(b)(1) and (2) are subject to audit. The Department has determined that it is also necessary to apply the consumer protection requirements in the proposed amendments to §3.3839 to policyholders and applicants for all long-term care insurance policies, not just partnership policies. The Department has determined that prospective policyholders and applicants for non-partnership policies are entitled to the same consumer protections as those for partnership policies. The Department's position is that in order to fulfill its regulatory functions pursuant to Chapter 1651 of the Insurance Code with regard to long-term care insurance, the same consumer protections must be afforded to both partnership and non-partnership long-term care applicants and policyholders. The Department is authorized to adopt the proposed amendments to the §3.3839 requirements for non-partnership policies under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

Proposed new §3.3839(a)(8), (9) and (10) and the proposed amendments to existing §3.3839(b) that provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance, as applicable to partnership policies, implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. Included in §23 are the requirements specified in proposed new §3.3839(a)(8), (9) and (10) and the proposed amendments to existing §3.3839(b) that provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance.

Existing §3.3839(c) and (d) are proposed to be redesignated as §3.3839(b) and (c) because of the proposed redesignation of existing §3.3839(b) as proposed §3.3839(a)(11).

§3.3842. Appropriateness of Recommended Purchase. Existing §3.3842 provides that in recommending the purchase or replacement of any long-term care insurance policy or certificate, the company and the agent shall make reasonable efforts to determine the appropriateness of the recommended purchase or replacement. This requirement, which is proposed to be redesignated as §3.3842(a), constitutes the entirety of existing §3.3842. The proposed amendments to §3.3842 add several new requirements relating to the suitability standards of the insurer, health service plan, or other entity (issuer) marketing long-term care insurance. These requirements apply to both partnership and non-partnership long-term care insurance coverage. Proposed new §3.3842(b)(1) - (3) requires that each issuer develop and use suitability standards to determine whether the purchase or replacement of a long-term care policy is appropriate to the needs of the applicant, train its agents in the use of the issuer's suitability standards, and maintain a copy of its suitability standards that is available to the Commissioner for inspection upon request.

Proposed new §3.3842(c) requires that the agent and issuer develop suitability procedures to determine whether the applicant meets the issuer's standards. These procedures must consider the following factors: the applicant's ability to pay for the proposed coverage and other pertinent financial information; the applicant's goals and needs with respect to long-term care; and the values, benefits, and costs of the applicant's existing insurance as compared to the values, benefits, and costs of the recommended purchase or replacement.

Proposed new §3.3842(d) requires the issuer or, if an agent is involved, the agent to make reasonable efforts to obtain the information required in proposed new §3.3842(c) and that the efforts shall include presentation to the applicant of the Long-Term Care Personal Worksheet that is in proposed new Form Number LHL560(LTC) specified in §3.3829(b)(8)(H). Under proposed new §3.3842(d), the issuer may request the applicant to provide additional information on the Personal Worksheet to comply with the issuer's suitability standards. However, if the issuer requests such additional information, the issuer must comply with the following requirements that are specified in proposed new §3.3842(d)(1) - (3): (i) a copy of the issuer's Personal Worksheet that includes the additional information must be filed with the Department for approval at least 60 days prior to use; (ii) the filing is subject to the requirements and procedures in Chapter 3, Subchapter A of this title; and (iii) the filing should be submitted to the Filings Intake Division of the Department.

Proposed new §3.3842(e) requires the completed Long-Term Care Personal Worksheet to be returned to the issuer prior to the issuer's consideration of the applicant for coverage; however, this is not required for sales of employer group long-term care insurance. Proposed new §3.3842(f) prohibits the sale or dissemination of information obtained through completion of the Long-Term Care Personal Worksheet. Proposed new §3.3842(g) requires the issuer to use suitability standards that it has developed pursuant to §3.3842 in determining the appropriateness of issuing long-term care insurance to an applicant. Proposed new §3.3842(h) requires agents to use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

Proposed new §3.3842(i) requires issuers to provide to the applicant at the same time the Personal Worksheet is provided the proposed new disclosure Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance. This form provides important information to the consumer concerning the general functions of a long-term care insurance policy, Medicare and Medicaid as those programs relate to long-term care insurance, the availability of a Shopper's Guide for Long-Term Care, the availability of a senior health insurance counseling program, and general information concerning long-term care facilities. This disclosure form will help the applicant decide whether or not it is prudent to purchase a long-term care policy. Additionally, proposed new §3.3842(i)(1) - (6) specify the requirements and procedures that apply to proposed new Form Number LHL567(LTC), including text size and content, recommended format, and filing and approval procedures as applicable. A representation of proposed new Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance is in §3.3842(i)(7).

Proposed new §3.3842(j) addresses actions to be taken if the issuer determines that the applicant does not meet its financial suitability standards or if the applicant has declined to provide the requested information. If either of these events occur, the proposed subsection provides that the insurer may either reject the application or, if the issuer does not opt to reject the application, the issuer is required to send the applicant a letter in accordance with proposed new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. If the issuer elects to send the applicant a Suitability Letter to comply with the requirements of proposed new §3.3842(j), the Suitability Letter must comply with the proposed requirements and procedures specified in §3.3842(j)(1) - (4), including text size and content. The content of the letter is specified in proposed new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. The letter will inform an applicant that the issuer has reviewed the financial information provided by the ap-

plicant on the personal worksheet and has determined that the applicant is not financially suitable to purchase long-term care insurance and that review of the application has been suspended or that the applicant has not provided any or has provided insufficient financial information for the issuer to make a determination as to the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended.

Proposed new §3.3842(b) - (j) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §24 of the NAIC Long-Term Care Model Regulations, which pertain to Suitability. These §24 requirements are specified in proposed new §3.3842(b) - (j). Section 24 requires the use of the proposed disclosure form LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance that is specified in §3.3842(i)(7) and the proposed Suitability Letter specified in proposed new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter as represented in §3.3842(j). The Department has determined that it is also necessary to apply the consumer protection requirements in proposed new §3.3842(b) - (h) to issuers and their agents who market non-partnership long-term care policies, not just partnership policies. The Department has determined that applicants for non-partnership policies are entitled to the same consumer protections as those for partnership policies. The Department's position is that in order to fulfill its regulatory functions pursuant to Chapter 1651 of the Insurance Code with regard to long-term care insurance, the same consumer protections must be afforded to both partnership and non-partnership long-term care applicants. The Department is authorized to adopt the proposed new §3.3842(b) - (h) requirements for non-partnership policies under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits. Existing §3.3844, pertaining to nonforfeiture and contingent benefits in long-term care policies and certificates, addresses: (i) requirements for the offering of nonforfeiture benefits and the provision of contingent benefits upon lapse in subsection (a); (ii) requirements for nonforfeiture benefit provisions in subsection (b); (iii) requirements for nonforfeiture benefit options in subsection (c); (iv) nonforfeiture and contingent benefit standards/requirements in subsection (d); (v) requirements for insurers offering a shortened benefit period in subsection (e); (vi) required disclosure of nonforfeiture benefits in subsection (f); and (vii) requirements for contingent nonforfeiture benefits in subsection (g). No changes are proposed to existing §3.3844 (a), (b), (d), or (f). An amendment is proposed to §3.3844(c)(3) to correct the erroneous word "shorten" to read "shortened." No changes are proposed to §3.3844(g)(1); however, a new §3.3844(g)(2) is proposed.

Proposed new §3.3844(g)(2) provides that in addition to the provision in §3.3844(g)(1) for the triggering of contingent nonforfeiture benefits on lapse, such contingent nonforfeiture benefits shall be triggered for policies or certificates with limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium specified in the proposed table in §3.3844(g)(2) based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio specified in proposed §3.3844(g)(4)(B) is 40 percent or more. Proposed §3.3844(g)(2) also provides that unless otherwise required, policyholders must be notified at least 45 days prior to the due date of the premium reflecting the rate increase. A contingent nonforfeiture benefit is a type of nonforfeiture benefit that becomes available to the policyholder when the contingency of a substantial rate increase occurs. The triggers for a substantial rate increase are contained in the tables in §3.3844(g)(1) and §3.3844(g)(2) and are expressed as a function of the issue age of the insured and the percent increase over initial premium that the insured paid.

The proposed revised contingent nonforfeiture benefit on lapse provision for policies with limited premium payment periods are necessary to require insurers to include these protections in their policies, and it is in the best interest of consumers who purchase policies on such payment plans to be able to receive greater protections if their policies lapse. The reasons for this are the following. The contingent nonforfeiture benefit on lapse is triggered every time an insurer increases the premium rate to a level that corresponds to the issue age of the insured at the time of the rate increase and the corresponding percent increase over the initial premium that the insured paid. Once the policyholder receives notice of a substantial rate increase the policyholder has 120 days to either pay the substantial rate increase or allow the policy to lapse and choose from the insurer's offer to: (i) reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that the required premium payments are not increased; or (ii) convert the coverage to a paid-up policy with a shortened benefit period. Therefore, the contingent nonforfeiture benefit on lapse provisions provide a safety net to policyholders who are forced to allow their long-term care policies to lapse because they are unable to pay a substantial rate increase.

Proposed new §3.3844(g)(4)(A) and (B) require the insurer to make certain offers to the insured for a policy or certificate with a fixed or limited premium payment period when there is a substantial rate increase and the policy has lapsed within 120 days of the due date of the premium that was substantially increased. The insurer must offer to the policyholder the option to either: (i) reduce the policy or certificate benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; or (ii) convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period.

Proposed new §3.3844(g)(4)(C) requires the insurer to notify the policyholder that a lapse or default at any time during the 120-day

period shall be deemed to be the insured's election of the offer to convert as set forth in §3.3844(g)(4)(B).

The proposed amendments to §3.3844(e) limit the application of subsection (e) to contingent nonforfeiture benefits upon lapse in the event of a default in payment of premiums in accordance with §3.3844(g)(1). The proposed amendments also provide that §3.3844(e) does not apply to contingent nonforfeiture benefits upon lapse in accordance with §3.3844(g)(2), which provides that a contingent nonforfeiture benefit on lapse is also triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium as set forth in the table Triggers for a Substantial Premium Increase in §3.3844(g)(2) based on certain specified factors. The proposed addition of this revised contingent nonforfeiture benefit on lapse provision will provide consumers with greater protections if their policies lapse. This provision ensures that, in the event that an insured is unable to pay the substantial rate increase and is therefore forced to let their policy lapse, the insured will receive at least some benefits for the premiums he or she has paid in over the years.

The proposed amendments to §3.3844 that amend subsection (e) and add new paragraphs (2) and (4) to subsection (g) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the nonforfeiture benefit requirements in the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC nonforfeiture benefit requirements for partnership policies are in §28D(4), D(6), E, and E(1) of the NAIC Long-Term Care Model Regulations, relating to Nonforfeiture Benefit Requirements. Section 28D(4), D(6) , E, and E(1) are specified in the proposed amendments to §3.3844(e), (e)(3), (g)(2), and (4).

The Department has determined that it is also necessary to apply the proposed new contingent nonforfeiture benefit requirements for limited premium payment policies in the proposed amendments to §3.3844(e) and (g) to non-partnership policies and insureds for all long-term care insurance policies, not just partnership policies and insureds.

The application of the proposed new nonforfeiture and contingent nonforfeiture benefit requirements to non-partnership policies and insureds is necessary to provide the same benefits to these insureds as is provided to partnership policy insureds. This is necessary to ensure that those insureds covered by non-partnership policies will also receive some benefits if they are unable to pay the higher premiums and are required to allow their policies to lapse. The Department has determined that insureds covered under non-partnership policies should receive the same consumer protections and benefits as insureds covered under partnership policies. There is no regulatory or public interest reason to exempt non-partnership policy insureds from these consumer protection requirements and benefits. To the contrary, there are significant regulatory and public interest reasons for providing all long-term care insureds the same consumer protections and benefits. Providing the same consumer protections and benefits to all long-term care insureds will mean that all long-term care insurance policyholders in Texas will be uniformly treated in the event that an insured is unable to pay the substantial rate increase and is therefore forced to let their policy lapse. Like the partnership policy insured, the non-partnership policy insured will receive at least some benefits for the premiums he or she has paid in over the years. The Department's position is that in order to fulfill its regulatory functions pursuant to Chapter 1651 of the Insurance Code with regard to long-term care insurance that the same consumer protections must be afforded to both partnership and non-partnership long-term care applicants and policyholders. The Department is authorized to adopt the proposed amendments to §3.3844(e) and (g) requirements for non-partnership policies under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

§3.3848. Requirements for Limited Premium Payment Options in Long-Term Care Policies, Certificates, and Riders. The regulatory requirements in proposed §3.3848, which apply to both partnership and non-partnership long-term care policies, govern noncancellation, guaranteed renewability, and return of premium practices for long-term care plans with limited premium payment options. Proposed new §3.3848(a) specifies the definition and applicability and proposed new §3.3848(b) specifies the requirements for limited premium payment options in long-term care plans. Long-term care policies, certificates, and riders with limited premium payment options limit premium payments to a single payment or to a stated number of years not to exceed 10 years and must comply with Subchapter A and Subchapter Y of Chapter 3 in Title 28 of the Texas Administrative Code and with the additional requirements specified in §3.3848(b).

The proposed requirements in §3.3848(b)(1) and (2) include: (i) notice on the face page of the policy or certificate that the plan has a limited premium payment option; and (ii) the provisions in long-term care policies, certificates, and riders with limited premium payment options must be at least as favorable as the requirements and provisions specified in §3.3848. Proposed §3.3848(b)(3) - (5) specify the requirements for three types of limited premium payment policies, certificates, and riders, including single-premium payment option, one-to-four-year premium payment options, and five-to-ten year premium payment options.

Single-premium payment option policies must be noncancellable and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(3) that states the premiums are paid by a single premium, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured. One-to-four year premium payment option policies must be noncancellable, and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(4) that states the premiums are paid over a period of [n] (n may equal 1, 2, 3, or 4) years, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured.

For those policies, certificates, and riders with a five-to-ten year premium payment option, a provision must be included in the policy, certificate, or rider that provides for a return of premium upon cancellation, as provided in the Return of Premium Schedule in

§3.3848(b)(5)(C)(ii) and must be accompanied by the disclosure notice specified in §3.3848(b)(5)(C)(i). The return of Premium Schedule chart in §3.3848(b)(5)(C)(ii) specifies the percentage of premium that the insurer is required to return to the insured expressed as a function of the premium payment option (5, 6, 7, 8, 9, and 10 year premium payment options) and of the number of completed years prior to the policy, certificate or rider being canceled and must comply with the requirements specified in §3.3848(b)(5)(C)(ii)(I) and (II), including text font size and format. Proposed §3.3848(b)(5)(D) and (E) provide a formula for using the Return of Premium chart to determine the total return of premium amount.

The provisions in proposed §3.3848 are not required by SB 22 or the DRA. The proposed requirements, which apply to both partnership and non-partnership policies, are proposed to protect Texas insureds who have limited premium payment plans from unfair cancellation, nonrenewal, and return of premium practices.

Proposed new §3.3848 is proposed pursuant to the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including partnership and non-partnership plans.

§3.3849. Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies. Existing §3.3849 relating to 1997 effective dates and grace period, is being repealed, and the proposed repeal is also published in this edition of the *Texas Register.* Proposed new §3.3849 specifies certification requirements for insurers that issue partnership and non-partnership policies to associations and marketing standards for associations, as defined in the Insurance Code §1251.052, that market partnership and non-partnership policies. Insurers that issue such policies to associations are required under proposed §3.3849(a)(1) to file with the Department the partnership and/or non-partnership policy and certificate, a corresponding outline of coverage, and an annual certification of the association's compliance with marketing standards for partnership and/or non-partnership policies and certificates in accordance with the Insurer Certification of Association Marketing Compliance specified in §3.3849(e)(1)(F). A representation of proposed Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates is specified in new Figure: 28 TAC §3.3849(e)(1)(F).

Proposed new §3.3849(a)(2) provides that no group long-term care partnership and/or non-partnership policy or certificate may be issued to an association unless the insurer files with the Department the information required in §3.3849(a)(1).

Proposed new §3.3849(e)(1)(A) - (D) specify the requirements and procedures that apply to the Insurer Certification of Association Marketing Compliance Form, including text content, text font size, recommended format, and filing for approval as applicable. Proposed new §3.3849(e)(2) requires that the initial certification be submitted to the Department between January 1, 2009 and January 31, 2009, for the calendar year 2008, and thereafter be submitted annually between January 1 and January 31 for the preceding calendar year.

Proposed new §3.3849(e)(3) provides that the certification form is an informational filing pursuant to §3.5(b)(1) of this title (relating to Filing Authorities and Categories) and is subject to the requirements and procedures in Chapter 3, Subchapter A of this title. Proposed new §3.3849(e)(4) specifies where the annual completed certification form should be filed. This requirement is necessary to provide information to assist the Department in monitoring each association's compliance with the §3.3849 requirements, including an association's compliance with marketing standards for partnership and non-partnership policies and certificates in accordance with the Insurer Certification of Association Marketing Compliance. The monitoring will enable the Department to identify possible violations, including unfair marketing practices, in a timely manner so that the Department can take corrective action to protect association members. Additionally, the proposed certification form in §3.3849(e)(1)(F) will ensure timely and efficient filing of the required certification information with the Department.

Proposed new §3.3849(b) requires advertisements for long-term care partnership and non-partnership insurance to be filed with the Department in accordance with §3.3838(1) (relating to Filing Requirements for Advertising). This requirement is necessary to enable the Department to timely identify and prevent unfair or deceptive advertising to association members who are considering applying for long-term care insurance coverage. This will help to ensure that association members are protected from unscrupulous and dishonest sales and enrollment practices.

Proposed §3.3849(c)(1) requires an association to disclose in any long-term care partnership and/or non-partnership insurance solicitation to its members: (i) the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and (ii) a brief description of the process under which the policies and the insurer issuing the policies were selected. Under proposed §3.3849(c)(2), an association is required to disclose to its members the fact of any interlocking directorates or trustee arrangements between the association and the insurer. The Department is proposing these new requirements in order to make consumers aware of factors, such as the financial arrangements between the insurer and the association and the extent of the insurer selection process, that will enable them to more effectively evaluate the pros and cons of the long-term care insurance solicitation. Also, more consumers will have information to enable them to more readily identify possible bias or deception in the marketing or solicitation of long-term care products by the association. These types of information will enable association members to be more than just pro forma participants in the purchase of their long-term care insurance if they so choose.

Proposed new §3.3849(d) requires an association's board of directors to review and approve the insurance policies and compensation arrangements the association has with the insurer. This requirement will enable the association's board of directors to examine and evaluate the long-term care benefits being purchased by the association's members and the financial arrangements between the insurer and the association to ensure that they are in the best interest of the members of the association.

Proposed new §3.3849(a) - (d) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pur-

suant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. The provisions in proposed §3.3849(a) - (d) are consistent with the provisions in §23 in the Model Regulations. While §23 of the Model Regulations does not specifically require a certification form, §23C(8) of the Model Regulations includes the requirement that insurers make the annual certification that is proposed in §3.3849(a)(1)(C).

The Department has determined that it is also necessary to apply the consumer protection requirements in proposed new §3.3849 to insurers, their agents, and associations that market non-partnership long-term care policies, not just partnership policies. The Department has determined that members of associations being solicited for non-partnership policies should receive the same consumer protections as members of associations being solicited for partnership policies. There is no regulatory or public interest reason to exempt association member applicants for non-partnership policies from these consumer protection requirements. In fact, there are significant regulatory and public interest reasons for providing all association member applicants for long-term care coverage the same consumer protections. Providing the same consumer protections to all long-term care association member applicants will mean that that all consumers who are members of associations in Texas will be uniformly protected from unscrupulous or dishonest marketing practices that can cause economic harm to the consumers.

§3.3860. Policy Summary Requirements for Non-partnership Life Insurance Policies That Provide Long-Term Care Benefits. Proposed new §3.3860 sets forth the delivery and content requirements for the policy summary for non-partnership life insurance policies that provide long-term care benefits by rider. The proposed requirements do not apply to any long-term care partnership policy. Proposed §3.3860(a) specifies that at the time of delivery of a life insurance policy that provides long-term care benefits by rider the insurer shall also deliver a policy summary. Proposed §3.3860(a) also provides requirements for policy summary delivery for direct response solicitations. Proposed §3.3860(a)(1) - (5) specify the policy summary content requirements: (1) an explanation of how the benefits interact with other components of the policy; (2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefit; (3) any exclusions, reductions, and limitations on benefits; (4) a statement that the long-term care inflation protection option required by §3.3820 (relating to Requirement to Offer Inflation Protection) and the long-term care inflation protection provisions required for partnership policies by §3.3872 (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) are not available under this policy; and (5) if applicable to the policy type, a disclosure of the effects of exercising other rights under the policy; a disclosure of guarantees related to the cost of insurance charges, and a disclosure of current and projected lifetime benefits. Proposed §3.3860(b) provides that the provisions of the policy summary may be incorporated into a basic life insurance illustration that is required to be delivered in accordance with Chapter 21 Subchapter N of Title 28, relating to Life Insurance Illustrations. Proposed §3.3860(c) specifies that any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit by rider, is in benefit payment status, a monthly report must be provided to the policyholder. Additionally, proposed §3.3860(c) specifies the information the monthly report is required to contain. The provisions in proposed §3.3860 are necessary to provide important information to the consumer to assist in determining whether to purchase a long-term care policy that is funded by a life insurance policy. Proposed §3.3860 is necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a long-term care policy that is funded by a life insurance policy be consistent with the provisions in §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). The policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements include the provisions in §6J and §6K of the NAIC Long-Term Care Model Act. Proposed §3.3860 is consistent with the §6J and §6K requirements.

§3.3870. Exchange Requirements for Long-Term Care Partnership Policies. Proposed new §3.3870 specifies the requirements for the exchange of an existing long-term care policy for a new long-term care partnership policy. Proposed new §3.3870(a) addresses requirements for notification to policyholders eligible for exchange and the requirements for the offer of exchange. The proposed requirements in subsection (a) include the following: (i) any insurer that advertises, markets, sells, or issues partnership policies is required to offer on a one-time basis to all policyholders or certificate holders that were issued long-term care coverage on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate; and (ii) the insurer is required to offer the option to exchange in writing by December 31, 2009. The Department is proposing the December 31, 2009 date as the cut-off date for insurers to offer the option to insureds to exchange any already purchased non-partnership policies for partnership policies in order to allow insurers sufficient time to take the necessary steps to have the product on the market and available to insureds who have already purchased non-partnership policies.

Proposed new §3.3870(b) specifies the methods by which insurers may make the new coverage available, including: by adding a rider or endorsement to the existing policy or by exchanging the existing policy or certificate for a new partnership policy or certificate. Proposed new §3.3870(b)(2)(A) specifies the conditions for exchange for new coverage that has an actuarial value of benefits equal to or lesser than the actuarial value of the benefits of the existing coverage. Proposed new §3.3870(b)(2)(B) specifies the conditions for exchange for new coverage that has an actuarial value of benefits exceeding the benefits of the existing coverage.

Proposed new §3.3870(c) addresses the general requirements for the exchange of an existing long-term care policy or certificate for a partnership policy or certificate. These proposed requirements which are specified in §3.3870(c)(1) - (5) are: (1) All offers of policy exchanges must be made on a nondiscriminatory basis. (2) An exchange offer shall be deferred to all policyholders who are currently eligible for benefits, within an elimination period on

a claim, or who would not be eligible to apply for coverage due to issue age limitations under the new policy, until such time when such condition expires. (3) All rates for exchanges must be in accordance with §3.3831 (relating to Standards and Rates); exchange policies may be underwritten and the premium may be increased in accordance with §3.3831. (4) The new coverage offered must be on a currently approved form. (5) In the event of an exchange the insured shall not lose any rights, benefits, or built-up value under the original policy.

Proposed new §3.3870(d) provides that policies issued pursuant to this section shall be considered exchanges and not replacements.

Proposed new §3.3870(e) requires that an insurer is required to report exchanges made pursuant to §3.3870 on a one-time basis for the 2009 reporting period (to be reported by June 30, 2010) on Form Number LHL562(LTC) specified in §3.3837(a)(4).

SB 22 establishes a partnership for long-term care program in Texas, and the Department is proposing to adopt minimum standards for an approved long-term care partnership benefit plan. These new partnership policies will be available upon the adoption of the new minimum standards for partnership policies. Under the DRA, policies sold prior to the establishment of the partnership program may be exchanged for partnership policies, and the terms and requirements of such policy exchanges are left to the discretion of each individual state. After careful review of the relevant issues and stakeholder input, the Department is proposing the requirements in new §3.3870 to regulate long-term care policy exchanges in Texas. The Department has determined that it is beneficial to insureds to provide them an opportunity to exchange their existing policy for a partnership policy. This exchange of existing policies for partnership policies will give Texas residents the opportunity to purchase long-term care policies that have the advantages of asset disregard and estate recovery benefits, which their existing non-partnership policies do not have.

§3.3871. Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies. Proposed new §3.3871 applies only to long-term care partnership policies and specifies the standards and reporting requirements for approved long-term care partnership policies. In addition to the required filing and approval pursuant to §3.3873 of this subchapter (relating to Filing Requirements for Long-Term Care Partnership Policies), any policy or certificate marketed or represented to qualify as a long-term care partnership policy or certificate must comply with the requirements specified in §3.3871(a)(1)(A) - (D): (i) the insured individual must be a resident of Texas when coverage first became effective under the policy, and if the policy or certificate is later exchanged for a different long-term care policy or certificate the individual was a resident of Texas when the coverage under the first policy became effective; (ii) a partnership policy must be a tax qualified policy under the provisions of §3.3847 (relating to Qualified Long-Term Care Insurance Contracts: Prohibited Representations); (iii) the policy is issued with and retains inflation protection coverage which meets the inflation standards based on the insured's attained age; and (iv) the effective date of the partnership policy must be the date that the partnership policy is issued or the date the application for the partnership policy was signed. Proposed §3.3871(a)(1)(A) - (D) are necessary to establish a Partnership Program in Texas in accordance with the DRA and SB 22 enacted by the 80th Legislature. The state Partnership Program is intended to promote consumers' purchase of long-term care insurance from insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased coverage. Adopted by the Texas Health and Human Services Commission, these special rules generally allow the individual to protect assets equal to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries.

Proposed new §3.3871(a)(1)(A), (B) and (C) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Pursuant to §1917(b)(1)(C)(iii)(I), (II) and (IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I), (II), and (IV)), the partnership policy must meet the general requirements of those sections in the DRA. Proposed §3.3871(a)(1)(A), (B) and (C) are consistent with §1917(b)(1)(C)(iii)(I), (II) and (IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I), (II), and (IV)).

The proposed effective date in §3.3871(a)(1)(D) that provides that the effective date of the partnership policy is the date that the partnership policy is issued is consistent with the effective date in 42 U.S.C. §1396p, Historical and Statutory Notes, "Expansion of State Long-Term Care Partnership Program," Pub. L. 109-171, Title VI, § 6021, Feb. 8, 2006, 120 Stat. 68; (a) Expansion Authority, (3) "Effective Date." The proposed effective date in §3.3871(a)(1)(D) that provides that the alternative effective date is the date that the application for the partnership policy was signed is based on input from stakeholders.

A policy or certificate represented or marketed as a long-term care partnership policy or certificate must be accompanied by a disclosure notice (a representation of which is specified in §3.3871(a)(2)(B)(vii)) that explains the benefits associated with the policy or certificate in accordance with the requirements in §3.3871(a)(2)(A) and (B). While proposed new §3.3871(a)(2)(A) and (B) pertaining to the required disclosure notice are not required by SB 22 or the DRA, the Department is proposing these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to provide necessary information to the insured to protect the insured from inadvertently losing partnership status and to inform the insured of various essential facts relating to the partnership policy. The required disclosure notice, titled "Important Information Regarding the Texas Long-Term Care Insurance Partnership Program," provides essential information to the insured relating to certain disclosures, including: (i) the policy purchased qualifies for the Texas partnership program; (ii) the partnership policy may protect the insured's assets through "asset disregard" under the Texas Medicaid program; (iii) the meaning of "asset disregard" and the fact that the purchase of a partnership policy does not guarantee the ability to disregard assets and does not automatically qualify the insured for Medicaid; (iv) the long-term care policy purchased confers partnership status as of the effective of the policy; (v) what could disqualify one's policy status as a partnership policy; and (vi) how the insured can obtain additional information on the partnership policy program. The notice, which is approximately one and one-half pages long, must be in at least 12-point type and must follow the order of the information presented in §3.3871(a)(2)(B)(vii). The text in the notice is mandated; the format for the form is a recommended

format. An insurer may format the mandated text in a different format from that specified in §3.3871(a)(2)(B)(vii) if the insurer files the form for review and approval by the Commissioner in accordance with the procedures in §3.3871(a)(2)(B)(iii) and (vi). This Partnership Status Disclosure Notice is not required by SB 22 or the DRA. The disclosure notice is necessary to ensure that individuals who purchase partnership policies have information in a separate document that accompanies the partnership policy that explains the benefits of the partnership program. Additionally, this notice will also be helpful in notifying family members or others who are administering the estate of the insured of the partnership status of the policy and of the estate recovery exemptions available for benefits paid under a partnership policy. The requirements and procedures related to the disclosure notice are necessary for the following reasons: (i) the 12-point type requirement will assist the consumer to more easily read and comprehend the information in the notice; and (ii) while the text and order of presentation of the information in the forms is mandated by the DRA, insurers will have flexibility with regard to the formatting of the forms subject to Department approval.

Proposed new §3.3871(a)(2)(B)(ix) requires that when an insurer is made aware that a policyholder has initiated an action that will result in the loss of partnership status, the insurer must advise the policyholder in writing of how to retain the partnership status if possible. Proposed new §3.3871(a)(2)(B)(x) requires that when a partnership plan loses partnership status, the insurer must explain in writing to the policyholders the reason for the loss of status. While proposed new §3.3871(a)(2)(B)(ix) and (x) are not required by SB 22 or the DRA, the Department is proposing these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to provide important information to the insured to enable the insured to retain the partnership status of the policy if possible and to explain to the insured why there has been a loss of partnership status. These provisions will help protect the insured from inadvertently losing partnership status and will provide vital information to the insured concerning any loss of partnership status by the insurer. Because of the important benefits of a partnership long-term care policy, including the advantages of asset disregard and estate recovery benefits, it is in the insured's interest to be informed about any possible loss of the partnership status of the long-term care policy. With this information, the insured may have the opportunity to take steps to either prevent the loss of partnership status or to replace the policy that has lost partnership status with another partnership policy.

Proposed new §3.3871(b) specifies new reporting requirements for insurers that issue partnership policies. In accordance with §1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VI) and (v)), all issuers of partnership policies or certificates must provide regular reports to the Secretary of the Department of Health and Human Services (Secretary) in accordance with regulations to be developed by the Secretary. As provided under proposed §3.3871(b)(1) - (3), such information shall include but not be limited to the following: (i) notification of when insurance benefits provided under a partnership policy have been paid and the amount of such benefits, (ii) notification regarding when such policies terminate, and (iii) any other information the Secretary determines is appropriate. Proposed new §3.3871(b) implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Section 1917(b)(1)(C)(iii)(VI) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VI)) includes the requirements that are proposed in §3.3871(b). Proposed new §3.3871(b) is necessary to provide Department rules that are consistent with the DRA reporting requirements for insurers that issue long-term care partnership policies. The information that insurers report to the Secretary of Health and Human Services will enable the Secretary to monitor the partnership program in Texas in accordance with the insurer reporting requirements established under the DRA. The Department is authorized to adopt the proposed new §3.3871 pursuant to the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including partnership plans.

§3.3872. Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates. Proposed new §3.3872 sets forth the inflation protection requirements for long-term care partnership policies and certificates. Proposed new §3.3872(1) specifies that for a person who is less than 61 years of age as of the date of purchase, the policy or certificate must provide compound annual inflation protection from the date of purchase until the person attains age 61. Proposed new §3.3872(1)(A) requires the insurer to offer to each applicant at the time of purchase the option to purchase compound annual inflation protection that automatically increases each year on a compounded basis at a rate of not less than 5.0 percent annually throughout the interval of coverage; the inflation protection is required to automatically increase benefits each year on a compounded basis. Proposed new §3.3872(1)(B) specifies that if the applicant declines the offer of not less than 5.0 percent compound annual inflation protection, then the insurer must offer and the applicant must purchase and retain compound annual inflation protection until the insured attains age 61 or goes on claim status, whichever comes first. The inflation protection is required to automatically increase benefits each year on a compounded basis at a rate that the insured elects which may be in a range of from one percent to four percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U). Proposed new §3.3872(1)(C) specifies that a person who is less than 61 years of age who has purchased a long-term care partnership policy or certificate with the required compound inflation protection may upon attaining 61 years of age choose to amend the compound inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(2). Proposed new §3.3872(2) specifies that for a person who is between 61 and 76 years old, the policy must provide some acceptable level of inflation protection until the person attains 76 years of age. Proposed new paragraph (2)(A) specifies that regardless of the insured's health status the insurer must offer inflation protection and the insured must accept and retain inflation protection until the insured attains age 76 or goes on claim status. Proposed new §3.3872(2)(A) - (D) specify that acceptable inflation protection includes: (i) regardless of the insured's health status, the insurer must offer and the insured must purchase and retain inflation protection until the insured attains age 76 or goes on claim status, whichever comes first; (ii) acceptable coverage includes automatic annual inflation protection, either simple or compound, paid with either level or stepped premium; (iii) the Inflation protection may be in a range of from one percent to five percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U); and (iv) a person who is

less than 76 years of age who has purchased a long-term care partnership policy or certificate with the required inflation protection may upon attaining 76 years of age choose to amend the inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(3). Proposed new §3.3872(3) specifies that for a person who is 76 years old, inflation protection may be provided but is not required. Proposed new §3.3872(4) specifies that an option to purchase inflation protection in the future does not constitute compliance with the requirements in §3.3872(1) and (2). Proposed new §3.3872 is necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Section 1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) includes the requirements that are proposed in §3.3872.

§3.3873. Filing Requirements for Long-Term Care Partnership Policies. Proposed new §3.3873(a) specifies the prior approval requirements that apply to any partnership policy, certificate, or endorsement that is to be delivered or issued for delivery in this state. Proposed new §3.3873(a)(1) requires that each partnership policy, certificate, or endorsement must be filed with the Department and approved in accordance the procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and §3.3873(b) and (c) as applicable. Proposed new §3.3873(a)(2) requires that each partnership policy, certificate, or endorsement filing must include Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form specified in §3.3873(a)(2)(F). Proposed new §3.3873(a)(2)(A) - (F) set forth the requirements and procedures that apply to Form Number LHL570(LTC), including text content and font size, order of information presented, format requirements, and filing and approval requirements if applicable. The proposed certification form specifies the elements of information that are required to be provided by each insurer for each partnership policy, certificate, or endorsement that is filed by the insurer for approval by the Commissioner for use under the Qualified Partnership Program. Pursuant to §1917(b)(5)(B)(iii) of the Social Security Act as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(B)(iii)), the Commissioner of Insurance, when implementing a qualified state long-term care insurance partnership program, is authorized to certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)) and principally include certain specific provisions of the 2000 NAIC Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act. The certification form to be filed by the insurer requests information relating to: (i) in Section I, general information relating to the insurer's name and address, a contact person for information relating to the filing, the policy form number(s) or other identifying information; for a policy form not previously approved, copies of the policy forms including any riders or endorsements must be included; and for a policy form previously approved, only identifying policy information must be included; (ii) in Section II, the insurer's response regarding whether the specified requirements of the Model Regulations and Model Act are met with respect to all policies and certificates that are intended to be included under the Qualified Partnership Program; and (iii) in Section III, the insurer's certification to the Commissioner that all of the attached or identified policy forms, riders and endorsements meet all of the requirements of the Model Regulations and Model Act that are specified in the Federal Deficit Reduction Act of 2005 and that all of the answers, accompanying information, and other information contained in the certification form are true, correct and complete.

Proposed new §3.3873(b) sets forth the requirements and procedures for the filing of a policy, certificate, or endorsement that has not been previously approved by the Commissioner. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the proposed requirements in §3.3873(b)(1) - (4), including (i) the policy, certificate, or endorsement must be filed with the Department and approved by the Commissioner, and Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form must be submitted for each policy, certificate, or endorsement form submitted for partnership approval; (ii) the policy, certificate, or endorsement form must be in at least 10 point type; (iii) the policy form filing must be filed at least 60 days prior to use and is subject to the requirements and procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements For Filings and Departmental Actions Related to Such Filings); and (iv) and any policy form filing should be filed with the Filings Intake Division of the Texas Department of Insurance.

Proposed new §3.3873(c) specifies the requirements and procedures for insurers requesting to use a previously approved non-partnership long-term policy as a long-term care partnership policy. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the proposed requirements in §3.3873(c)(1) - (6), including: (i) the insurer must file Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form and a copy of any endorsement that is needed to comply with the partnership policy requirements; (ii) the policy form numbers or other identifying information must be included on Form Number LHL570(LTC); (iii) the filing must be approved by the Commissioner prior to the use of the form as a partnership policy; (iv) a previously approved policy or certificate does not have to be included in the filing; (v) the filing made must be made at least 60 days prior to use and is subject to the procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements For Filings and Departmental Actions Related to Such Filings); and (vi) the filing should be submitted to the Filings Intake Division of the Texas Department of Insurance.

Proposed new §3.3873 is necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Section 1917(b)(5)(B)(iii) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(B)(iii)) authorizes the insurance commissioner of a state implementing a qualified state long-term care insurance partnership ("Qualified Partnership") to certify to the state Medicaid agency that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. Proposed §3.3873, including the information to be provided in the proposed Long-Term Care Partnership Program Insurer Certifi-

cation Form, are necessary to provide the Commissioner of Insurance with the information necessary to provide a certification for the policies.

§3.3874. Insurer Requirements for Agents That Market Partnership Policies and Certificates. Proposed new §3.3874 specifies insurer requirements for reporting information to the Department on agents that market long-term care partnership plans. Proposed new §3.3874(a)(1) - (3) specify training verification and certification requirements for insurers with agents who market partnership plans. These proposed requirements are: (i) obtaining of verification that an agent has received the training specified in §19.1022 of this title (relating to Long-Term Care Partnership Certification Course); (ii) insurer certification to the Commissioner that each agent who sells partnership policies or certificates on behalf of the insurer complies with the training requirements of this subsection; and (iii) insurer's maintenance of verification records for at least four years; records are subject to review by the Department or its designee at any time. The initial certification (for the period from the effective date of the rules to January 31, 2009) must be submitted on Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(B).

Proposed new §3.3874(b) specifies the requirements and procedures that apply to proposed Form Number LHL571(LTC) and Form Number LHL572(LTC), including text content, text font size, recommended format, and filing and approval requirements and procedures as applicable.

Proposed new §3.3874(c)(1) - (3) specify the filing requirements for the agent training certification by each insurer. An insurer offering partnership policies or certificates must submit: (i) Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form for the initial certification, and (ii) Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form for each subsequent annual certification. The initial certification form, Form Number LHL571(LTC), is to be used for certification by the insurer for the initial certification period (from the effective date of the rules to January 31, 2009). This form will be used by the insurer to certify that each individual who is currently selling partnership policies has completed training and demonstrated evidence of understanding long-term care partnership policies. There will be a grace period from the effective date of the rules to January 31, 2009, during which agents who have a license to sell accident and health insurance but may not have completed the specialized partnership training will be eligible to sell partnership policies. Insurers will file the annual certification Form Number LHL572(LTC) annually with the Department beginning in January 2010 to certify that each individual who currently sells partnership policies for the insurer has completed the required training before the agent sells or solicits the insurer's partnership products. Proposed new §3.3874 implements the provision of SB 22, codified as Insurance Code §1651.104 and §1651.105. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Section 1651.105 requires that each long-term care benefit plan issuer that offers a plan under the partnership for long-term care program shall certify to the Commissioner, in the form required by the Commissioner that each individual who sells on behalf of the issuer has complied with the training requirements of §1651.105(a). Section 1917(b)(1)(C)(iii)(V) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(V)) and §1651.105 of the Insurance Code include the requirements that are proposed in §3.3874.

Update of Obsolete Statutory Citations. The Department is proposing amendments to §§3.3801, 3.3802, 3.3803, 3.3804, 3.3821, 3.3829, 3.3833, 3.3834, 3.3839, and 3.3846 to update obsolete statutory citations to the Insurance Code as a result of the non-substantive revision of the Insurance Code. Insurance Code Article 1.03A, which is referenced in §3.3801, was enacted as §36.001, in the non-substantive Insurance Code revision, Acts 1999, 76th Legislature, Chapter 101, §1, effective September 1, 1999 and amended by Acts 2003, 78th Legislature, Chapter 206, §15.01, effective June 11, 2003. Insurance Code Article 3.70-12, which is referenced in §§3.3801, 3.3802, 3.3803, and 3.3829 was enacted as Chapter 1651, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §4, effective April 1, 2005. Insurance Code Article 3.70-12 §2(4), which is referenced in §3.3803, was enacted as §1651.003, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §4, effective April 1, 2005. Insurance Code Article 3.51-6 §1(a)(6), which is referenced in §3.3821, was enacted as §1251.056, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Insurance Code Article 3.50 §1(6), which is referenced in §3.3821, was enacted as §1131.064 in the non-substantive Insurance Code revision, Acts 2001, 77th Legislature, Chapter 1419, §2, effective June 1, 2003. Insurance Code Article 3.51-6 §1(a), which is referenced in §3.3833, was enacted as §1251.001, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Insurance Code Article 3.70-2(A)(4), which is referenced in §3.3834, was enacted as §1201.054 in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Insurance Code Article 21.21, which is referenced in §3.3839 was enacted as Chapter 541, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §2, effective April 1, 2005. Insurance Code Article 3.70-12 §2, which is referenced in §3.3839, was enacted as §1651.003, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §4, effective April 1, 2005. Article 3.51-6 §1(d)(2)(ii), which is referenced in §3.3846, was enacted as §1251.103, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Article 3.70-3(A)(2), which is referenced in §3.3846, was enacted as §1201.208, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005.

FISCAL NOTE. Ana Smith-Daley, Deputy Commissioner for the Life and Health Division, has determined that for each year of the first five years the proposed amendments and new sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT/COST NOTE. Ms. Smith-Daley has further determined that for each year of the first five years the proposed amendments and new sections are in effect, there are several public benefits anticipated as a result of the proposal, and there

will be potential costs for persons required to comply with the proposal.

Overall, the anticipated public benefits of this proposal include: (i) the implementation of a state partnership for long-term care program in Texas that is intended to promote consumers' purchase of long-term care insurance from insurers; (ii) the adoption of minimum standards for a long-term care benefit plan that qualifies as an approved plan under the state partnership for long-term care program that will enable consumers to purchase long-term care partnership insurance and thereby be eligible for asset disregard equal to the long-term care insurance benefits that have been received to the date of Medicaid application from a partnership policy should they ever apply for Medicaid long-term care benefits; (iii) adoption of consumer protection requirements for long-term care non-partnership insurance, annuity contracts, and life insurance policies that provide long-term care benefits by rider that will provide insureds under these types of products with the same consumer protection requirements as those for consumers who purchase partnership long-term care insurance; and (iv) a re-organization of the Subchapter Y rules on long-term care insurance into four divisions to clarify the different types of policies and certificates that are being regulated under Subchapter Y and the specific provisions applicable to the various types of policies and certificates being regulated; this will assist the Department in the implementation of the rules and regulated entities with compliance with the rules.

Those insurers and agents marketing on behalf of those insurers that currently write and that will continue to write non-partnership long-term care policies will incur costs to comply with the proposed amendments and new sections. While no individual or entity is required by law to write long-term care policies, either partnership or non-partnership, those insurers and agents marketing on behalf of those insurers that opt to write such policies will also incur costs to comply with the proposal. However, with regard to long-term care partnership policies, most of these costs are the result of the legislative enactment of SB 22 and the federal Deficit Reduction Act of 2005 (DRA) and are not the result of the adoption, enforcement, or administration of the proposed amendments and new sections. With regard to the writing of non-partnership policies, the costs that will be incurred to comply with the proposed amendments and new sections are the result of this proposal, pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004.

The anticipated public benefits and the potential costs required to comply with this proposal are discussed in the following section-by-section analysis.

Proposed Amendments to §3.3826. The proposed amendments to §3.3826, pertaining to Limitations and Exclusions, add new paragraph (6) to subsection (a) to permit exclusions and limitations for expenses for services or items paid under another long-term care or health insurance policy. The anticipated public benefit will be to ensure that policyholders will only be indemnified for the amount of an actual loss and thereby prevent the policyholder from receiving a double recovery on a claim filed. By preventing double recoveries on claims, the premium rates for long-term insurance benefit plans will not experience rate increases that would occur if double recoveries were factored into the premium rate. The proposed amendments to §3.3826 also add new subsection (b) to specify that with respect to this section the "state of policy issue" is the state in which the individual policy or certificate was originally issued and to permit exclusions and limitations for payment for services provided outside the United States. However, as required by the DRA, the issuer of long-term care insurance policies and certificates being claimed against in a state other than where the policy or certificate was issued must cover those services that would be covered in the state of policy issue irrespective of any licensing, registration, or certification requirements for providers in the other state. The anticipated public benefit will be that policyholders will receive the benefits and services for which they have paid, regardless of their state of residency or where they are at the time that the services are needed.

Proposed Amendments to §3.3829. The proposed amendments to §3.3829, pertaining to Required Disclosures, specify the two disclosure forms (the Long-Term Care Insurance Personal Worksheet and the Long-Term Care Insurance Potential Rate Increase Disclosure Form) that must be provided to an applicant at the time of application or enrollment, or if the method of application does not allow for delivery at that time, the information must be provided at the time of delivery of the policy or certificate. Under existing §3.3832(b)(3)(A), the person to whom the policy is issued is permitted to return the policy within 30 days (or more, if so provided for in the policy) of its delivery to that person, and if the policy is returned, the person shall receive the return of the premium in full.

The anticipated public benefits from requiring the dissemination of the two forms to the applicant at the time of application or enrollment are: (i) The Long-Term Care Insurance Potential Rate Increase Disclosure Form provides detailed information to the applicant concerning the potential for a rate increase prior to the applicant purchasing a long-term care policy; this will assist the applicant in determining whether to purchase the policy in light of the applicant's financial circumstances. (ii) The Long-Term Care Insurance Personal Worksheet provides information for the insurer to assess the applicant's suitability to purchase a long-term care policy prior to the applicant's purchasing a long-term care policy. The Long-Term Care Personal Worksheet requires the insurer to obtain detailed information from any individual who is considering the purchase of a long-term care policy. Such information includes the applicant's current insurance and premium payments, the applicant's income and net worth. The Long-Term Care Potential Rate Increase Disclosure Form requires the insurer to provide detailed information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, the insurer's rate history, and also a disclosure of the insurer's right to increase premiums and policy options in the event of a rate increase. The anticipated public benefit resulting from the use of these new forms is that the additional information obtained from the applicant on the Personal Worksheet and the information provided to the applicant regarding potential rate increases on the Potential Rate Disclosure Form will assist the insurer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. Also, additional questions have been added to the proposed Long-Term Care Personal Worksheet in the section titled "Questions Related to Your Needs" and include questions to applicants regarding: (i) knowledge of what inabilities trigger long-term care benefits; (ii) awareness and meaning of the term "cognitive impairment"; (iii) understanding of policy limitations; and (iv) what type of long-term care service the applicant anticipates utilizing. The anticipated public benefit is that these direct questions to consumers are an effective method of more promi-

nently disclosing and emphasizing some of the most important limitations that are currently in long-term care policies that need to be considered by consumers prior to purchasing a long-term care policy. This will result in more consumers being better informed about such limitations before making the important decision of whether to purchase a long-term care policy. The proposed amendments to §3.3829(b)(8) specify the requirements and procedures that apply to the two disclosure forms, including text size and content, recommended format, and filing and approval procedures as applicable. The anticipated public benefit of these requirements and procedures are: (i) the 12-point type requirement will assist the consumer to more easily read and comprehend the information in the forms; and (ii) while the text and order of presentation of the information in the forms is mandated by the DRA, insurers will have flexibility with regard to the formatting of the forms subject to Department approval.

The proposed amendments to §3.3829 implement the provision of SB 22, codified as Insurance Code §1651.104 which requires that a partnership policy be consistent with provisions established under the DRA. The DRA requires a partnership policy to conform with specific consumer protection provisions of the NAIC Long-Term Care Model Regulations and Model Act. These NAIC consumer protection requirements for partnership policies include the provisions of §9 of the NAIC Long-Term Care Model Regulations, which pertain to Required Disclosures of Rating Practices to Consumers, and included in §9 is the requirement to use the new forms specified in §3.3829(b)(8)(H) and (I). These consumer protection provisions, which are required under the DRA, are necessary to require the use of these new forms in the marketing of long-term care policies.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3829 will incur no additional cost as a result of the amendments, except for the proposed additional questions in the part of the form entitled "Questions Related to Your Needs," because the amendments are the result of the legislative enactment of SB 22, and any cost to comply result directly from the enactment of SB 22 and the DRA and are not from the adoption, enforcement, or administration of the proposed amendments. However, those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3829 that add the additional questions in the part of the form entitled "Questions Related to Your Needs," will incur minimal additional costs as a result of the requirement of these additional questions on the Personal Worksheet. These additional questions will add approximately a half page to the Long-Term Care Personal Worksheet, which may result in additional costs for paper, printing, and postage. Based on the Department's experience, an additional printed page costs approximately $0.05 per page. Insurers that print the additional questions in the part of the Personal Worksheet entitled "Questions Related to Your Needs," on a separate page from the questions in the remainder of the worksheet could incur as much as an additional printing cost of $0.05 per disclosure form. However, the Department does not anticipate that any necessary return envelope or return postage costs will increase for the additional questions because this part of the form is no more than a half-page that is in addition to the part of the form that is required by SB 22, the DRA, and §9 of the NAIC Long-Term Care Model Regulations, as previously explained. The actual total costs will vary based on factors that pertain to each individual insurer, including the size of the insurer; the type of office equipment, including printers and computers; and the number of forms that are needed.

The proposed amendment to §3.3826(a) that adds new paragraph (6) and proposed new §3.3826(b) implements the provision of SB 22, codified as Insurance Code §1651.104 which requires that a partnership policy be consistent with provisions established under the DRA. The DRA requires a partnership policy to conform with specific consumer protection provisions of the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC consumer protection requirements for partnership policies include the provisions of §6B of the NAIC model regulations, which pertain to Policy Practices and Provisions, and included in §6B are the requirements specified in §3.3826(a)(6) and (b).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3826 will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3826 will incur costs relating to the amendment of policy forms that may include the following: personnel, computer reprogramming, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed new §3.3829(b)(8), relating to use of the new Personal Worksheet form, will incur costs relating to the following: personnel, computer reprogramming, agent training, and printing and distribution. The estimated probable costs related to the new Personal Worksheet form are detailed in the preceding paragraph. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs. In order to comply with proposed §3.3829(b)(8), which requires the use of the Potential Rate Increase form, there will only be the printing and distribution costs for the new form because a version of this form is already in use by those insurers that write non-partnership policies. Again, the actual cost for compliance with proposed §3.3829(b)(8) will vary based on the individual insurer and can be calculated by the insurer based on the company's own operation and needs.

Proposed Amendment to §3.3830. Proposed new §3.3830(h), pertaining to Requirements for Application Forms and Replacement Coverage, specifies the requirements that apply: (i) if a long-term care policy is being replaced by a life insurance policy with a long-term care rider that accelerates life insurance benefits to cover the cost of long-term care; (ii) if the policy being replaced is a life insurance policy; and (iii) if a life insurance policy with a long-term care rider that accelerates benefits for long-term care is replaced by another such policy. The anticipated public benefits will be the provision of minimum standards of conduct

to be observed by agents and insurers in long-term care policy replacements and the provision of information to the purchaser of the replacement policy that is necessary to make an informed decision about the replacement.

The proposed amendments to §3.3830 implement the provision of SB 22, codified as Insurance Code §1651.104 which requires that a partnership policy be consistent with provisions established under the DRA. The DRA requires a partnership policy to conform with specific consumer protection provisions of the NAIC Long-Term Care Model Regulations and Model Act. These NAIC consumer protection requirements for partnership policies include the provisions of §14 of the NAIC Long-Term Care Model Regulations, which pertain to Requirements for Application Forms and Replacement Coverage, and included in §14 are the requirements specified in §3.3830(h).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3830 will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed new §3.3830(h), relating to Requirements for Application Forms and Replacement Coverage will incur costs relating to the following: personnel, computer reprogramming, agent training, printing, and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Proposed Amendments to §3.3837. Section 3.3837, pertaining to Reporting Requirements, addresses certain insurer reporting requirements for long-term care policies. The proposed amendments to §3.3837(a) specify the requirements for insurers to report information to the Commissioner on a statewide basis regarding long-term care insurance policy or certificate replacements and lapses. These requirements include: (i) existing requirements in §3.3837(a)(1) for maintenance of agent records relating to sales attributable to long-term care products; (ii) requirements in §3.3837(a)(2) for record maintenance and annual reporting of data concerning the 10 percent of each insurer's agents with the greatest percentages of policy or certificate lapses and the 10 percent of each insurer's agents with the greatest percentages of replacements during the preceding calendar year; and (iii) new requirements in §3.3837(a)(3) and (4) for insurers to report company totals for the number of lapsed and replacement long-term care policies sold as a percentage of its total number of long-term care policies in force as of the end of the preceding year. Insurers are required to report the information pertaining to the reporting of the top 10 percent of the insurer's agents with the greatest percentages of policy or certificate lapses or replacements during the preceding calendar year in accordance with the Long-Term Care Insurance Replacement and Lapse Reporting Form and in an electronic format prescribed by the Department. Specifically, each insurer must maintain records for each agent that is in the 10 percent of that insurer's agents with the greatest percentage of replacements and for each agent that is in the 10 percent of that insurer's agents with the greatest percentage of lapses. The Insurance Replacement and Lapse Reporting Form requires information on each agent's name, number of policies sold by the agent, number of policies replaced and lapsed by the agent, and number of replacements and lapses as percent of number of policies sold by the agent. Insurers are required to report company totals for the number of lapsed and replacement long-term care policies sold as a percentage of its total number of long-term care policies in force as of the end of the preceding year in accordance with the part of the Insurance Replacement and Lapse Reporting Form relating to Company Totals and in an electronic format prescribed by the Department. The anticipated public benefit from the reporting of the lapsed and replacement long-term care policy data specified in the Insurance Replacement and Lapse Reporting Form will be the provision of data to the Department that will assist in identifying possible market conduct problems and will thereby enable the Department to act more quickly and efficiently to resolve such problems before they result in harm to consumers. In the existing as well as the draft rules we state "Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The anticipated public benefit from the reporting of the lapsed and replacement long-term care policy data specified in the Insurance Replacement and Lapse Reporting Form will be the provision of data to the Department that will assist the Department in monitoring agent activities regarding the sale of long-term care. The anticipated public benefit resulting from the electronic submission of the required data will be increased efficiency in the Department's compiling and analyzing of data regarding lapsed and replacement long-term care policies. It should also be more efficient for insurers to report such data by electronic means.

The proposed amendments to §3.3837(a)(1) - (4) implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with the provisions established under the DRA. The DRA requires a partnership policy to conform with specific reporting requirement provisions of the NAIC Long-Term Care Model Regulations and Model Act. These NAIC reporting requirements for partnership policies include the provisions of §15 of the NAIC Long-Term Care Model Regulations, which pertain to Reporting Requirements. Section 15 requires insurers to use the new form specified in §3.3837(a)(2) to report the data specified in proposed amendments to subsection (a)(1) - (4).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(a) will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies should not incur additional costs as a result of the proposed amendments to §3.3837(b) because this data is currently required to be reported on the NAIC form.

Insurers are required under the proposed amendments to §3.3837(b), pertaining to insurer reporting requirements relating to rescissions, to report the same information required in the existing form LTC RESCIND that is currently adopted by reference in §3.3848. The information, however, is required to be reported in accordance with the newly named Rescission Reporting Form for Long-Term Care Policies. There are no proposed changes to the existing reporting requirements relating to rescissions.

The proposed amendments to §3.3837(b) require each insurer to report to the Commissioner, by no later than June 30 annually for the preceding calendar year, all rescissions of long-term care insurance policies or certificates except those rescissions voluntarily effectuated by an insured. Insurers are required to report for each rescission the policy form number, the policy and certificate number, the name of the insured, the date of the policy issuance, the date or dates that a claim or claims were submitted, the date of rescission, and a detailed reason for each rescission. The required information must be submitted electronically in a format prescribed by the Department. The data regarding rescissions of long-term care policies will assist the Department in monitoring insurers' activities regarding the sale of long-term care insurance. The anticipated public benefit resulting from the electronic submission of the required data will be increased efficiency in the Department's compiling and analyzing of data regarding rescissions of long-term care insurance policies or certificates. It should also be more efficient for insurers to report such data by electronic means.

The proposed amendments to §3.3837(b) implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with the provisions established under the DRA. The DRA requires a partnership policy to conform with specific reporting requirement provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC reporting requirements for partnership policies include the provisions of §15 of the NAIC Long-Term Care Model Regulations, which pertain to Reporting Requirements. Section 15 requires insurers to use the new form specified in §3.3837(b) to report the data specified in Figure: 28 TAC §3.3837(b).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(b) will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that continue to write or that opt to write non-partnership long-term care policies should not incur additional costs as a result of the proposed amendments to §3.3837(b) because this data is currently required to be reported in accordance with the existing form LTC RESCIND that is currently adopted by reference in §3.3848.

The proposed amendments to §3.3837(c), pertaining to reporting requirements for claims denied by class of business, define the terms "claim" and "denied" for purposes of reporting data relating to long-term care insurance claim denials. Proposed amendments to §3.3837(c)(2) require insurers to use the proposed new Long-Term Care Claim Denials Reporting Form to comply with the reporting requirements. Under the proposed amendments, each insurer is required to report 11 data elements for both state data and nationwide data for all long-term care insurance claim denials under in-force long-term care insurance policies, including total number of long-term care claims reported, total number of long-term care claims denied/not paid, number of claims not paid due to preexisting condition exclusion, and number of claims not paid due to waiting period not being met. The proposed amendments require the data to be submitted electronically in a format prescribed on the Department's website. If an insurer has a particularly large percentage of long-term care claim denials, this may indicate improper or unfair claim settlement practices. The anticipated public benefit resulting from the use of the new form will be that the collection and reporting of such data will assist the Department in identifying possible improper claim settlement practices and will thereby enable the Department to act more quickly and efficiently to resolve such problems before they result in harm to consumers. The data will further assist the Department in conducting more efficient and thorough regulation of long-term care claim settlement practices by identifying insurers with claim settlement trends that may indicate improper or unfair claim settlement practices, thereby enabling the Department to focus market conduct examination resources on insurers displaying problematic trends. The anticipated public benefit resulting from the electronic submission of the required data will be increased efficiency in the Department's compiling and analyzing of data regarding denials of claims filed under long-term care insurance policies or certificates. It should also be more efficient for insurers to report such data by electronic means.

The proposed amendments to §3.3837(c) implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with the provisions established under the DRA. The DRA requires a partnership policy to conform with specific reporting requirement provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC reporting requirements for partnership policies include the provisions of §15 of the NAIC Long-Term Care Model Regulations, which pertain to Reporting Requirements. Section 15G contains the definitions in proposed new §3.3837(c)(1) and the requirement that insurers must report state and nationwide data relating to claim denials that is in the proposed new form specified in §3.3837(c)(2).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(c) will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(c), should not incur additional costs as a result of the proposed amendments to §3.3837(c) because this data is currently required to be reported on the NAIC form.

The proposed amendments to §3.3837(d) address additional reporting requirements for insurers marketing long-term care partnership policies in Texas. Proposed new §3.3837(d) requires each insurer to report to the Department by June 30 of each year the information required in §32.107 of the Human Resources Code. Each insurer must specify the number of approved partnership plans purchased in the state during the preceding calendar year and the average age of individuals purchasing approved partnership plans during the preceding calendar year. The required information must be reported in accordance with the Long-Term Care Policies Sold Reporting Form specified in §3.3837(e). The required information includes reporting for two long-term care partnership policy types: comprehensive (institutional and community care) and nursing home (institutional only). Each insurer must submit the required information electronically in a format prescribed on the Department's website. SB 22 enacted new §32.107 of the Human Resources Code that requires

the Texas Health and Human Services Commission (HHSC) to report this information in a biennial report to the Legislature by not later than September 30 of each even-numbered year. The purpose of the report is to provide information to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. The Department will report this data to the HHSC for use in fulfilling HHSC's requirements under §32.107 of the Human Resources Code. The anticipated public benefit resulting from the new reporting requirements and the use of the new form will be that the collection and reporting of the data required in the new form regarding partnership policies will facilitate the timely completion and submission of the Health and Human Services Commission's biennial report to the Legislature as required by §32.107 of the Human Resources Code. The data collected under §32.107 and contained in the HHSC biennial report will assist the Legislature in determining whether to continue the long-term care partnership program as provided under §32.107. The anticipated public benefit resulting from the electronic submission of the required data will be increased efficiency in compiling and analyzing of data regarding the progress of the partnership program in the state. It should also be more efficient for insurers to report such data by electronic means.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(d) will incur no additional cost as a result of the amendments. Any such costs for these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Proposed new §3.3837(e), pertaining to reporting requirements for non-partnership plans, requires that all insurers report to the Department by June 30 of each year the number of non-partnership plans sold in the state during the preceding calendar year and the average age of individuals purchasing the non-partnership plans during the preceding calendar year. The required information must be reported in accordance with the Long-Term Care Policies Sold Reporting Form specified in §3.3837(e). The required information includes reporting for four long-term care non-partnership policy types: comprehensive (institutional and community care); nursing home (institutional only); home health care (community-based services); and riders (attached to life policies or annuity contracts.) Each insurer must submit the required information electronically in a format prescribed on the Department's website. Proposed new §3.3837(e) implements the provision of SB 22, codified as Human Resources Code §32.107. Section 32.107 requires that not later than September 30 of each even-numbered year the Texas Health and Human Services Commission (HHSC) shall submit a report to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. Therefore, the Department has determined that the most effective approach to measuring the progress of the partnership program in Texas is to compare partnership data as required pursuant to proposed §3.3837(d) and non-partnership data as required pursuant to proposed §3.3837(e). While the Human Resources Code §32.107(a) requires the HHSC to submit the biennial report to the Legislature on the progress of the partnership program, any information that may be requested of the Department by the HHSC as provided in the Human Resources Code §32.107(b) will have to be requested from insurers by the Department pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004. The anticipated public benefit of collecting the required data on non-partnership plans will be the timely availability of data that will result in a more meaningful, comprehensive report to the Legislature on the progress of the partnership program that provides comparative information on both non-partnership and partnership policies.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(e) will incur costs relating to the following: personnel, computer reprogramming, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Proposed new §3.3837(f) provides new suitability reporting requirements for all insurers that market long-term care insurance policies in Texas. Insurers are required to provide suitability data on both non-partnership and partnership policies sold in Texas in accordance with the requirements indicated in the proposed Long-Term Care Suitability Reporting Form specified in §3.3837(f). The data is required to be reported to the Commissioner by no later than June 30 annually for the preceding calendar year. Insurers are required to report suitability data for long-term care partnership comprehensive (institutional and community care) and nursing home (institutional only) policies that includes total number of applications received, total number of applicants who declined to provide the personal worksheet information, total number of applicants who did not meet the suitability standards, and total number of applicants who chose to confirm after receiving a Suitability Letter. Proposed new §3.3837(f) requires insurers to report the same suitability data for long-term care non-partnership comprehensive, nursing home, and home health care policies, and riders attached to life policies and annuity contracts. The proposed reporting requirements require insurers to submit the data electronically in a format prescribed on the Department's website. The anticipated public benefit resulting from the new reporting requirements and the use of the new form will be that the collection and reporting of the data required in the new form will provide the Department with important information regarding the appropriateness of the marketing and sales of long-term care policies to Texas consumers. The data will provide an essential tool in the Department's monitoring of whether long-term care policies are being sold appropriately, i.e., to those who actually need the coverage. The data will assist the Department in identifying possible improper marketing practices and will thereby enable the Department to act more quickly and efficiently to resolve such problems before they result in harm to consumers. The anticipated public benefit resulting from the electronic submission of the required data will be increased efficiency in the Department's compiling and analyzing of data regarding the new suitability reporting requirements. The electronic reporting should also be more efficient for insurers to report such data by electronic means.

Proposed new §3.3837(f) requirements for reporting suitability data for partnership policies sold in Texas are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy

be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §24 of the NAIC Long-Term Care Model Regulations, which pertain to Suitability. Section 24 contains the requirement that insurers must report the long-term care partnership data specified in proposed new §3.3837(f).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3837(f) will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3837(f) pertaining to non-partnership policies, will incur costs relating to the following: personnel, computer reprogramming, agent training, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Proposed new §3.3837(g) contains the requirement in existing §3.3837(a)(5) that requires insurers to file an annual rate filing required under former Insurance Code Article 3.70-12 §4(b) (revised as Insurance Code §1651.053(c) as part of the non-substantive Insurance Code revision) to demonstrate compliance with the applicable loss ratios of this state and any other filing requirement adopted by the Commissioner relating to loss ratios. The requirement applies to both partnership and non-partnership long-term care policies. Existing §3.3837(a)(5) is proposed to be redesignated as new §3.3837(g) and amended to clarify that the demonstration of compliance with applicable loss ratio standards that is in the current rule is in addition to any demonstration required under §§3.3831(c)(2)(B) - (D) and that compliance with the statutory requirement, includes providing the following information by calendar duration and separately by form number: (i) calendar duration; (ii) first year issued; (iii) actual earned premium by duration; (iv) actual incurred claims; (v) actual calendar duration loss ratio; (vi) anticipated calendar duration loss ratio; and (vii) number of insured lives. This also applies to partnership and non-partnership long-term care policies. The proposed requirements in re-designated §3.3837(g) are necessary to clarify the information a company must provide in order to demonstrate compliance with the Insurance Code §1651.053(c)(1). Therefore, those insurers that opt to write partnership long-term care policies and those insurers that currently write or that opt to write non-partnership long-term care policies will not incur any additional cost as a result of the amendment.

Proposed Amendments to §3.3838. The proposed amendments to §3.3838(1), pertaining to Filing Requirements for Advertising, refine the requirements for the advertising of partnership and non-partnership long-term care insurance to exclude the necessity of filing institutional advertisements (as that term is defined in §21.102 of this title) if the advertisement only references long-term care insurance as a line of coverage. Institutional advertisements that provide details regarding the insurer's long-term care insurance products that go beyond merely identifying long-term care insurance as a line of coverage that is available from the insurer would continue to be subject to prior approval by the Commissioner, subject to the requirements in existing §3.3838. The proposed amendments to §3.3838(1) exclude from the filing and review requirements long-term care insurance advertisements that do not provide any details on the long-term care insurance product. Because these advertisements are not currently a source of false, misleading, or deceptive marketing practices, the Department has determined that the Commissioner's review is not necessary. The anticipated public benefit is more efficient and cost-effective advertising filing requirements for long-term care insurers. Also, the reduction in the number of institutional advertisements that are filed with the Department for review will enable the Department to more effectively utilize Departmental resources without compromising consumer protection. The Department will be able to redirect its resources to advertising practices that are a more frequent source of false, misleading, or deceptive marketing practices. There are no changes proposed to existing §3.3838(2) and (3). The amendments to §3.3838(1), which apply to both partnership and non-partnership policies, are not required by SB 22 or any other state or federal legislation but rather are proposed pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans. Those insurers that opt to write partnership long-term care policies and those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3838(1) will incur no additional cost as a result of the amendments. The amendments may be a cost savings measure for insurers because certain institutional advertisements that they are currently required to file will no longer be required to be filed.

Proposed Amendments to §3.3839. Section 3.3839, pertaining to Standards for Marketing, specifies the marketing procedures that must be established and implemented by each insurer, health care service plan, or other entity marketing, either directly or through its agents, partnership or non-partnership long-term care insurance in this state. Proposed new §3.3839(a)(8), (9) and (10) mandate three new requirements: (i) each insurer or other entity marketing long-term care insurance in this state must, at the time of solicitation, provide written notice to the prospective policyholder that a senior insurance counseling program is available; (ii) each insurer or other entity must provide to the applicant at the time of application an explanation of the contingent benefit upon lapse specified in §3.3844(g)(1), and if applicable, an explanation of the additional contingent benefit upon lapse provided to policies with fixed or limited payment periods provided in §3.3844(g)(2); and (iii) each insurer or other entity must provide to the applicant, at the time of application, copies of the Long-Term Care Personal Worksheet as specified in §3.3829(b)(8)(H) and the Long-Term Care Potential Rate Increase Disclosure Form as specified in §3.3829(b)(8)(I). The anticipated public benefits will be more consumers who are better informed about the availability of the senior insurance counseling program and therefore, more consumers who will

participate in the counseling program. The Health Information Counseling and Advocacy Program of Texas is the senior counseling program and is operated by the Department. The program provides consumer information on long-term care insurance, including planning, insurance basics, need for such coverage, costs, and methods of financing. This information will mean that more consumers will be able to make more informed decisions regarding the purchase of long-term care insurance. Another anticipated public benefit will be more consumers who are better informed about the contingent benefit on lapse provisions, including the additional contingent benefit upon lapse provided to policies with fixed or limited payment periods. A contingent lapse benefit allows the insured to either choose a reduced benefit amount to prevent premium increases or to convert their policy to a paid-up status. The required information will explain the different contingent benefit on lapse options that are available to a consumer if the consumer decides to allow their long-term care policy to lapse within 120 days of a substantial rate increase. With such information, more consumers will be aware of the possible range of benefits that they will have in the event that they are unwilling or unable to pay the long-term care premium in the face of a substantial rate increase by the insurer. This type of information will also assist consumers in making more informed decisions regarding the purchase of long-term care insurance.

As previously stated, the anticipated public benefit resulting from the use of these new forms, which is also required under proposed §3.3829, is that the additional information obtained from the applicant on the Personal Worksheet and the information provided to the applicant regarding potential rate increases on the Potential Rate Disclosure Form, which may affect the applicant's ability to continue to pay the premiums for the long-term care insurance, will assist the insurer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. From the perspective of marketing standards, the anticipated public benefit will be that each agent marketing long-term care insurance will have information pertaining to each applicant or potential applicant that will enable the agent to only sell long-term care insurance to individuals who are financially suitable to purchase such insurance.

The proposed amendments to §3.3839 provide that the required notices in existing §3.3839(b)(1) and (2), relating to the existence or non-existence of inflation protection provisions in each policyholder's policy, are also marketing procedure requirements, along with the other marketing procedure requirements specified in §3.3839(a), that are subject to Department audit to verify compliance. These current notices, which are redesignated as §3.3839(a)(11)(A) and (B), respectively, must be provided to each policyholder who purchases a policy that contains inflation protection provisions and to each policyholder who purchases a policy that does not contain inflation protection provisions. Existing §3.3839(b), which is proposed to be redesignated as §3.3839(a)(11), specifies the current requirements for providing the required notices to policyholders. No changes are proposed to the wording of the existing required notices or to the existing requirements for providing the notice to policyholders. The anticipated public benefit of requiring that the inflation protection notices in existing §3.3839(b)(1) and (2) are marketing procedure requirements subject to Department audit to verify compliance will be that insurers and other regulated entities will be required to establish an auditable procedure for verifying that they have complied with these notice requirements. This will enable the Department to more easily verify each insurer's compliance and to take corrective action when appropriate. The required notices are significant because they provide insureds with important information concerning: (i) the fact that even if an insured's long-term care policy does contain an inflation protection provision, the policy still may not cover all of the costs associated with long-term care; and (ii) the fact that if the policy does not contain an inflation protection provision, then based on current health care cost trends, the policy benefits may be significantly diminished depending on the amount of time between when the policy is purchased and when the policyholder becomes eligible for benefits.

Proposed new §3.3839(a)(8), (9) and (10) and the proposed amendments to existing §3.3839(b) that provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance, as applicable to partnership policies, implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. Included in §23 are the requirements specified in proposed new §3.3839(a)(8), (9) and (10) and the proposed amendments to existing §3.3839(b) that provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3839 will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed new §3.3839(a)(8), (9) and (10) will incur costs relating to: personnel, computer reprogramming, agent training, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; number of agents; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs. There will likely be other costs related to the requirement that the inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance. If agents are soliciting on behalf of an insurer, the agents will need some type of verifiable procedure to demonstrate that the required notice was provided to each prospective policyholder. This verification could be a signed form by the prospective policyholder indicating that the policyholder re-

ceived the inflation notice. The insurer will incur minimal additional costs for paper and printing as a result of this verification form. The cost will vary depending on whether the insurer opts to have a single form for each prospective policyholder or a multiple-page form with several lines on which several prospective policyholders can sign (similar to a doctor's office patient sign-in sheet). Based on the Department's experience, an additional printed page costs approximately $0.05 per page. Insurers that opt to have a single form for each prospective policyholder will incur greater paper and printing costs than the insurer that opts to have a multiple-page form with several lines on which several prospective policyholders can sign. An insurer, including an insurer that uses direct sales solicitations, can calculate its estimated costs based on the company's own operation and needs. There may also be record storage costs because the insurer will need to retain the forms for purposes of a Department audit. The total probable costs for maintaining such records will vary substantially based on business decisions made by individual insurers including choosing among numerous electronic forms of storage or various methods of physical storage. An insurer, however, has the information necessary to calculate its estimated costs based on the company's own operation and needs.

Proposed Amendments to §3.3842. Existing §3.3842, pertaining to Appropriateness of Recommended Purchase, requires that in recommending the purchase or replacement of any long-term care insurance policy or certificate, the company and the agent must make reasonable efforts to determine the appropriateness of the recommended purchase or replacement. This requirement, which is proposed to be redesignated as §3.3842(a), constitutes the entirety of existing §3.3842. The proposed amendments to §3.3842 add several new requirements relating to the suitability standards of the insurer, health service plan, or other entity marketing long-term care insurance (issuer). These requirements apply to both partnership and non-partnership long-term care insurance coverage. Proposed new §3.3842(b)(1) - (3) requires that each issuer develop and use suitability standards to determine whether the purchase or replacement of a long-term care policy is appropriate to the needs of the applicant, train its agents in the use of the issuer's suitability standards, and maintain a copy of its suitability standards that is available to the Commissioner for inspection upon request.

Proposed new §3.3842(c) requires that the agent and issuer develop suitability procedures to determine whether the applicant meets the issuer's standards. These procedures must consider the following factors: the applicant's ability to pay for the proposed coverage and other pertinent financial information; the applicant's goals and needs with respect to long-term care; and the values, benefits, and costs of the applicant's existing insurance as compared to the values, benefits, and costs of the recommended purchase or replacement.

Proposed new §3.3842(d) requires the issuer or, if an agent is involved, the agent to make reasonable efforts to obtain the information required in proposed new §3.3842(c) and that the efforts shall include presentation to the applicant of the Long-Term Care Personal Worksheet that is specified in §3.3829(b)(8)(H). Under proposed new §3.3842(d), the issuer may request the applicant to provide additional information on the Personal Worksheet to comply with the issuer's suitability standards. However, if the issuer requests such additional information, the issuer must comply with the specified filing requirements: (i) a copy of the issuer's Personal Worksheet that includes the additional information must be filed with the Department for approval at least 60 days prior to use; (ii) the filing is subject to the requirements and procedures in Chapter 3, Subchapter A of this title; and (iii) the filing should be submitted to the Filings Intake Division of the Department. The Long-Term Care Personal Worksheet requires the issuer to obtain detailed information from any individual who is considering the purchase of a long-term care policy. Such information includes the applicant's current insurance and premium payments, the applicant's income and net worth, the issuer's rate history, and also a disclosure of the insurer's right to increase premiums. The anticipated public benefit resulting from the use of this new form is that the additional information obtained from the applicant on the Personal Worksheet will assist the issuer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. Also, the additional questions that have been added to the proposed Long-Term Care Personal Worksheet in the section titled "Questions Related to Your Needs" include questions to applicants regarding: (i) knowledge of what inabilities trigger long-term care benefits; (ii) awareness and meaning of the term "cognitive impairment"; (iii) understanding of policy limitations; and (iv) what type of long-term care service the applicant anticipates utilizing. The anticipated public benefit is that these direct questions to consumers are an effective method of more prominently disclosing and emphasizing some of the most important limitations that are currently in long-term care policies that need to be considered by consumers and issuers prior to a consumer purchasing a long-term care policy. This will result in more consumers being better informed about such limitations before making the important decision of whether to purchase a long-term care policy. Additionally, because the issuer may request the applicant to provide additional information on the Personal Worksheet to comply with the issuer's suitability standards, the issuer is able to collect any additional specific information that the issuer has determined, based on the issuer's own experience, is necessary to ensure that each applicant purchases the appropriate product that is suitable to the applicant's goals and needs.

Proposed new §3.3842(e) requires the completed Long-Term Care Personal Worksheet to be returned to the issuer prior to the issuer's consideration of the applicant for coverage; however, this is not required for sales of employer group long-term care insurance.

Proposed new §3.3842(g) requires the issuer to use suitability standards that it has developed pursuant to §3.3842 in determining the appropriateness of issuing long-term care insurance to an applicant. Proposed new §3.3842(h) requires agents to use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

The anticipated public benefit resulting from the proposed requirements in §3.3842(b), (c), (d), (e), (g) and (h) will be more purchasers of long-term care insurance who are financially and otherwise suitable to make such a purchase. The new requirements require issuers to use objective measures to evaluate an applicant's suitability to purchase long-term care insurance by collecting detailed information regarding the applicant's assets, current insurance in-force, and the applicant's probable future insurance needs. This information is to be carefully evaluated by the issuer in light of the issuer's established suitability standards to ensure that each individual who purchases long-term care insurance is financially suitable to make such a purchase and that the product purchased is suitable to the individual's needs and goals.

Proposed new §3.3842(f) prohibits the sale or dissemination of information obtained through completion of the Long-Term Care Personal Worksheet. The anticipated public benefit resulting from this proposed prohibition is to provide reassurance of privacy of personal information to applicants who are being asked to provide to the issuer sensitive financial and personal information for purposes of the issuer making a suitability determination. The prohibition against the sale or dissemination of information should help allay the concerns that an applicant may have about providing the sensitive financial and personal information that is needed to evaluate the applicant's suitability for purchasing long-term care insurance and ensure that the individuals who purchase long-term care insurance are financially suitable to make such a purchase.

Proposed new §3.3842(i) requires issuers to provide to the applicant at the same time the Personal Worksheet is provided the proposed new disclosure Things You Should Know Before You Buy Qualified Long-Term Care Insurance. This form provides important information to the consumer concerning the general functions of a long-term care insurance policy, Medicare and Medicaid as those programs relate to long-term care insurance, the availability of a Shopper's Guide for Long-Term Care, the availability of a senior health insurance counseling program, and general information concerning long-term care facilities. This disclosure form is intended to help the applicant decide whether it is prudent to purchase a long-term care policy. Additionally, proposed new §3.3842(i)(1) - (6) specify the requirements and procedures that apply to the proposed Things You Should Know disclosure form, including text size and content, recommended format, and filing and approval procedures as applicable. The anticipated public benefit resulting from the dissemination of the proposed new disclosure form is that the information provided will assist the consumer in determining whether it is prudent to purchase a long-term care policy. The anticipated public benefit of the requirements and procedures that pertain to the proposed Things You Should Know disclosure form are: (i) the 12-point type requirement will assist the consumer to more easily read and comprehend the information in the form, and (ii) while the text and order of presentation of the information in the form is mandated by the DRA, issuers will have flexibility with regard to the formatting of the form subject to Department approval.

Proposed new §3.3842(j) addresses actions to be taken if the issuer determines that the applicant does not meet its financial suitability standards or if the applicant has declined to provide the requested information. If either of these events occur, the issuer may either reject the application or, if the issuer does not opt to reject the application, the issuer is required to send the applicant a letter in accordance with the proposed new Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. If the issuer elects to send the applicant a Suitability Letter, the Suitability Letter must comply with the specified requirements and procedures, including mandated content and 12-point text. The letter will inform an applicant that the issuer has reviewed the financial information provided by the applicant on the Personal Worksheet and has determined that the applicant is not financially suitable to purchase long-term care insurance and that review of the application has been suspended or that the applicant has not provided any or has provided insufficient financial information for the issuer to make a determination as to the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended. The anticipated public benefit resulting from the use of the Suitability Letter is that applicants will receive important information concerning the status of their application. This information will indicate either that the issuer has determined that the applicant is not financially suitable to purchase long-term care insurance or that the financial information provided by the applicant is not sufficient for the issuer to make a determination regarding the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended. The Suitability Letter will further inform the applicant that the applicant may choose to continue the application process despite the determination that long-term care may not be a suitable purchase. This information is important because it alerts a consumer to the fact that their application for a long-term care policy is no longer being processed unless the consumer chooses to proceed with the purchase.

The proposed amendments to §3.3842 that add proposed new §3.3842(b) - (j) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §24 of the NAIC Long-Term Care Model Regulations, which pertain to Suitability and included in §24 are the requirements specified in proposed new §3.3842(b) - (j).

Those issuers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3842 will incur no additional cost as a result of the amendments. Any such costs, except those costs related to the information obtained in questions to the applicant on the Personal Worksheet that are in addition to those questions required in §9 (Required Disclosures of Rating Practices to Consumers) of the NAIC Long-Term Care Model Regulations, incurred by these issuers are the result of legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments. The estimated probable costs for the additional questions in the Personal Worksheet are detailed in this Public Benefit/Cost Note in the section entitled "Proposed Amendments to §3.3829."

Those issuers that are currently writing or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3842 will incur costs resulting from the adoption of the amendments. An issuer will incur costs to perform the following functions: (i) the development and use of suitability standards to determine whether the purchase or replacement of a long-term care policy is appropriate for the needs of the applicant; (ii) the training of its agents in the use of the issuer's suitability standards; (iii) maintaining a copy of its suitability standards that is available to the Commissioner for inspection upon request; (iv) the development of suitability procedures to determine whether the applicant meets the issuer's standards, including consideration of the following

factors pertinent financial information of the applicant; the applicant's goals or needs for long-term care; benefits and costs of the applicant's existing insurance compared to the recommended replacement benefits and costs; (v) the making of reasonable efforts, or, if an agent is involved, the agent making reasonable efforts, to obtain the necessary information to determine whether the applicant meets the issuer's standards; (vi) the obtaining of the completed Long-Term Care Personal Worksheet from the applicant prior to the issuer's consideration of the applicant for coverage; (vii) the use of the issuer's suitability standards in determining the appropriateness of issuing long-term care insurance to an applicant; (viii) the provision to the applicant at the same time the Personal Worksheet is provided the proposed new disclosure Things You Should Know Before You Buy Long-Term Care Insurance; and (x) sending of the required Suitability Letter when appropriate. These costs may include personnel to develop the suitability standards if the issuer has not already developed such standards or personnel to revise the issuer's suitability standards to conform to the new requirements and to develop suitability procedures to determine whether the applicant meets the issuer's standards These costs may also include personnel costs to train the issuer's agents in the use of the issuer's suitability standards if such training has not already been provided or if additional training is needed due to revised standards. There may be minimal personnel and storage costs for maintaining a copy of the issuer's suitability standards that is available to the Commissioner for inspection upon request. The estimated probable costs for the Personal Worksheet are detailed in this Public Benefit/Cost Note in the section entitled "Proposed Amendments to §3.3829." An issuer will incur costs for printing the required disclosure entitled Things You Should Know Before You Buy Long-Term Care Insurance. This disclosure printed in 12-point type is approximately one and one-half pages, and there will be costs for printing, envelopes, and postage. Based on the Department's experience, an additional printed page costs approximately $0.05 per page, an envelope and a return envelope cost approximately $0.05 each; postage for mailing the form to applicants will cost a maximum of $0.43 per applicant; and return postage for one to three pages of paper will cost a maximum of $0.43. The actual total costs for an issuer will vary based on factors that pertain to each individual issuer, including the size of the issuer; the type of office equipment, including printers and computers; and the number of forms that are needed. An issuer can calculate its estimated costs based on the company's own operation and needs. The Suitability Letter, which is required in certain specified circumstances under proposed §3.3842(j), printed in 12-point type is approximately one and one-half pages, and there will be costs for printing, envelopes, and postage. These probable costs will include an estimated $0.05 per printed page, approximately $0.05 each for an envelope and a return envelope; a maximum of $0.43 per applicant for postage for mailing; and a maximum of $0.43 for return postage. Again, the actual total costs for an issuer will vary based on factors that pertain to each individual issuer, including the size of the issuer; the type of office equipment, including printers and computers; and the number of letters that are needed. An issuer can calculate its estimated costs based on the company's own operation and needs.

Proposed Amendments to §3.3844. Existing §3.3844 addresses nonforfeiture and contingent benefits in long-term care policies and certificates. The proposed amendments to §3.3844 also address contingent nonforfeiture benefits in long-term care policies and certificates, both partnership and non-partnership policies. Proposed new §3.3844(g)(2) provides that in addition to the provision in §3.3844(g)(1) for the triggering of contingent nonforfeiture benefits on lapse, such contingent nonforfeiture benefits shall be triggered for policies or certificates with a limited premium paying period every time an issuer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium specified in the proposed table in §3.3844(g)(2) based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio specified in proposed §3.3844(g)(4)(B) is 40 percent or more. Proposed §3.3844(g)(2) also provides that unless otherwise required, policyholders must be notified at least 45 days prior to the due date of the premium reflecting the rate increase. A contingent nonforfeiture benefit is a type of nonforfeiture benefit that becomes available to the policyholder when the contingency of a substantial rate increase occurs. The triggers for a substantial rate increase are contained in the tables in §3.3844(g)(1) and §3.3844(g)(2) that are expressed as a function of the issue age of the insured and the percent increase over initial premium that the insured paid. The anticipated public benefit resulting from the revised contingent nonforfeiture benefit on lapse provision for policies with fixed or limited premium payment periods is that insurers will be required to include these protections in their policies, and it is in the best interest of consumers who purchase policies on such payment plans to be able to receive greater protections if their policies lapse. The reasons for this are the following. The contingent nonforfeiture benefit on lapse is triggered every time an insurer increases the premium rate to a level that corresponds to the issue age of the insured at the time of the rate increase and the corresponding percent increase over the initial premium that the insured paid. Once the policyholder receives notice of a substantial rate increase the policyholder has 120 days to either pay the substantial rate increase or allow the policy to lapse and choose from the insurer's offer to: (i) reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that the required premium payments are not increased; or (ii) convert the coverage to a paid-up policy with a shortened benefit period. Therefore, another anticipated public benefit to consumers is that the contingent benefit on lapse provisions provide a safety net to policyholders who are forced to allow their long-term care policies to lapse because they are unable to pay a substantial rate increase.

Proposed new §3.3844(g)(4)(A) and (B) require the insurer to make certain offers to the insured for a policy or certificate with a fixed or limited premium payment period when there is a substantial rate increase and the policy has lapsed within 120 days of the due date of the premium that was substantially increased. The insurer must offer to the policyholder the option to either: (i) reduce the policy or certificate benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; or (ii) convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. Proposed new §3.3844(g)(4)(C) requires the insurer to notify the policyholder that a lapse or default at any time during the 120-day period shall be deemed to be the insured's election of the offer to convert as set forth in §3.3844(g)(4)(B). The proposed amendments to §3.3844(e) limit the application of subsection (e) to contingent nonforfeiture benefits upon lapse in the event of a default in payment of premiums in accordance with §3.3844(g)(1). The

proposed amendments also provide that subsection §3.3844(e) does not apply to contingent nonforfeiture benefits upon lapse in accordance with §3.3844(g)(2), which provides that a contingent nonforfeiture benefit on lapse is also triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium as set forth in the table Triggers for a Substantial Premium Increase in §3.3844(g)(2) based on certain specified factors. The anticipated public benefit resulting from the addition of this revised contingent nonforfeiture benefit on lapse provision for policies with fixed or limited premium payment periods is that consumers will receive greater protections if their policies lapse. This provision ensures that, in the event that an insured is unable to pay the substantial rate increase and is therefore forced to let their policy lapse, the insured will receive at least some benefits for the premiums he or she has paid in over the years. The proposed amendments to §3.3844 that amend subsection (e) and add new paragraphs (2) and (4) to subsection (g) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the nonforfeiture benefit requirements in the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC nonforfeiture benefit requirements for partnership policies are in §28D(4), D(6), E, and E(1) of the NAIC Long-Term Care Model Regulations, relating to Nonforfeiture Benefit Requirements. Section 28D(4), D(6), E, and E(1) are specified in the proposed amendments to §3.3844(e), (e)(3), (g)(2) and (4).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3844 will incur no additional cost as a result of the amendments. Any such costs incurred by these insurers are the result of legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed amendments.

The proposal applies the proposed new nonforfeiture and contingent nonforfeiture benefit requirements to non-partnership policies and insureds for all long-term care insurance policies, not just partnership policies and insureds. The application of the proposed new nonforfeiture and contingent nonforfeiture benefit requirements to non-partnership policies and insureds is necessary to provide the same benefits to these insureds as is provided to partnership policy insureds. The anticipated public benefit is that those insureds covered by non-partnership policies will also receive some benefits if they are unable to pay the higher premiums and are required to allow their policies to lapse. The Department has determined that insureds covered under non-partnership policies should receive the same consumer protections and benefits as insureds covered under partnership policies. There is no regulatory or public interest reason to exempt non-partnership policy insureds from these consumer protection requirements and benefits. To the contrary, there are significant regulatory and public interest reasons for providing all long-term care insureds the same consumer protections and benefits. Providing the same consumer protections and benefits to all long-term care insureds will mean that all long-term care insurance policyholders in Texas will be uniformly treated in the event that an insured is unable to pay the substantial rate increase and is therefore forced to let their policy lapse. Like the partnership policy insured, the non-partnership policy insured will receive at least some benefits for the premiums he or she has paid in over the years.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3844, relating to the contingent nonforfeiture benefits on lapse that are available for a policy or certificate with a fixed or limited premium payment period will incur costs relating to the printing costs for modifying the existing policy forms to include these new provisions. Therefore, the Department anticipates that the costs associated with the proposed new nonforfeiture and contingent benefit requirements will involve the following cost components: personnel, computer reprogramming, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Proposed New §3.3848. The regulatory requirements in proposed §3.3848, pertaining to Requirements for Limited Premium Payment Options in Long-Term Care Policies, Certificates, and Riders, which apply to both partnership and non-partnership long-term care policies, govern noncancellation, guaranteed renewability, and return of premium practices for long-term care plans with limited premium payment options. Proposed new §3.3848(a) specifies the definition and applicability and proposed new §3.3848(b) specifies the requirements for limited premium payment options in long-term care plans. Long-term care policies, certificates, and riders with limited premium payment options limit premium payments to a single payment or to a stated number of years not to exceed 10 years and must comply with Subchapter A and Subchapter Y of Chapter 3 in Title 28 of the Texas Administrative Code and with the additional requirements specified in §3.3848(b). The proposed requirements in §3.3848(b)(1) and (2) include: (i) notice on the face page of the policy or certificate that the plan has a limited premium payment option; and (ii) the provisions in long-term care policies, certificates, and riders with limited premium payment options must be at least as favorable as the requirements and provisions specified in §3.3848. Proposed §3.3848(b)(3) - (5) specify the requirements for three types of limited premium payment policies, certificates, and riders, including single-premium payment option, one-to-four-year premium payment options, and five-to-ten year premium payment options. Single-premium payment option policies must be noncancellable and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(3) that states the premiums are paid by a single premium, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured. One-to-four year premium payment option policies must be noncancellable, and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(4) that states the premiums are paid over a period of [n] (n may equal 1, 2, 3, or 4) years, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured. For those

policies, certificates, and riders with a five-to-ten year premium payment option, a provision must be included in the policy, certificate, or rider that provides for a return of premium upon cancellation, as provided in the Return of Premium Schedule in §3.3848(b)(5)(C)(ii) and must be accompanied by the disclosure notice specified in §3.3848(b)(5)(C)(i). The return of Premium Schedule chart in §3.3848(b)(5)(C)(ii) specifies the percentage of premium that the insurer is required to return to the insured expressed as a function of the premium payment option (5, 6, 7, 8, 9, and 10 year premium payment options) and of the number of completed years prior to the policy, certificate or rider being canceled and must comply with the requirements specified in §3.3848(b)(5)(C)(ii)(I) and (II), including text font size and format. Proposed §3.3848(b)(5)(D) and (E) provide a formula for using the Return of Premium chart to determine the total return of premium amount. The provisions in proposed §3.3848 are not required by SB 22 or the DRA. The proposed requirements, which apply to both partnership and non-partnership policies, are proposed to protect Texas insureds who have limited premium payment plans from unfair cancellation, nonrenewal, and return of premium practices.

Those insurers that are currently writing non-partnership long-term care policies with limited premium payment options will be required to amend their policy forms to include the applicable renewability provision and the return of premium chart, if applicable. Insurers currently writing limited premium payment option policies will incur costs relating to the following: personnel, computer reprogramming, and printing and distribution of the amended policy forms. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer, type of office equipment, including printers and computers, employee salaries; and the number of policy forms that are needed. An insured can calculate its estimated costs based on the company's own operation and needs.

Those insurers that opt to write partnership or non-partnership limited premium payment option long-term care policies in the future will be required to include the applicable renewability provision in their policies and the return of premium chart, if applicable. Because the requirements will be in effect at the time such insurers initially write their policies, they will not incur any additional costs related to amending policy forms or computer programming for amended policy forms. An individual insurer should be able to include any costs related to the proposed requirements into their start-up business operating costs.

Proposed New §3.3849. Proposed new §3.3849, pertaining to Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations That Market the Policies, specifies certification requirements for insurers that issue partnership and non-partnership policies to associations and marketing standards for associations, as defined in the Insurance Code §1251.052, that market partnership and non-partnership policies. Insurers that issue such policies to associations are required under proposed §3.3849(a)(1) to file with the Department the partnership and/or non-partnership policy and certificate, a corresponding outline of coverage, and an annual certification of the association's compliance with marketing standards for partnership and/or non-partnership policies and certificates in accordance with the Insurer Certification of Association Marketing Compliance specified in §3.3849(e)(1)(F). Proposed new §3.3849(a)(2) provides that no group long-term care partnership and/or non-partnership policy or certificate may be issued to an association unless the insurer files with the Department the information required in §3.3849(a)(1). Proposed new §3.3849(e)(1)(A) - (D) specify the requirements and procedures that apply to the Insurer Certification of Association Marketing Compliance Form, including text content, text font size, recommended format, and filing for approval as applicable. Proposed new §3.3849(e)(2) requires that the initial certification be submitted to the Department between January 1, 2009 and January 31, 2009, for the calendar year 2008, and thereafter be submitted annually between January 1 and January 31 for the preceding calendar year. Proposed new §3.3849(e)(3) provides that the certification form is an informational filing pursuant to §3.5(b)(1) of this title and is subject to the requirements and procedures in Chapter 3, Subchapter A of this title. Proposed new §3.3849(e)(4) specifies where the annual completed certification form should be filed. The anticipated public benefit of the insurer filing the required information and certification relating to any association to which it has issued a long-term care partnership or non-partnership policy or certificate is that it provides necessary information to assist the Department in monitoring each association's compliance with the §3.3849 requirements, including an association's compliance with marketing standards for partnership and non-partnership policies and certificates in accordance with the Insurer Certification of Association Marketing Compliance. The monitoring will enable the Department to identify possible violations, including unfair marketing practices, in a timely manner so that the Department can take corrective action to protect association members. Additionally, the proposed certification form in §3.3849(e)(1)(F) will ensure timely and efficient filing of the required certification information with the Department.

Proposed new §3.3849(b) requires advertisements for long-term care partnership and non-partnership insurance to be filed with the Department in accordance with §3.3838(1) (relating to Filing Requirements for Advertising). The anticipated public benefit is that the Department's review of long-term care partnership and non-partnership advertising by associations and to associations will enable the Department to timely identify and prevent unfair or deceptive advertising to association members who are considering applying for long-term care insurance coverage. This will help to ensure that association members are protected from unscrupulous and dishonest sales and enrollment practices.

Proposed §3.3849(c)(1) requires an association to disclose in any long-term care partnership and/or non-partnership insurance solicitation to its members: (i) the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and (ii) a brief description of the process under which the policies and the insurer issuing the policies were selected. Under proposed §3.3849(c)(2), an association is required to disclose to its members the fact of any interlocking directorates or trustee arrangements between the association and the insurer. The anticipated public benefit is that more consumers will be aware of factors, such as the financial arrangements between the insurer and the association and the extent of the insurer selection process, that will enable them to more effectively evaluate the pros and cons of the long-term care insurance solicitation. Also, more consumers will have information to enable them to more readily identify possible bias or deception in the marketing or solicitation of long-term care products by the association. These types of information will enable association members to be more than just pro forma participants in the purchase of their long-term care insurance if they so choose.

Proposed new §3.3849(d) requires an association's board of directors to review and approve the insurance policies and compensation arrangements the association has with the insurer. The anticipated public benefit of this requirement is that the association's board of directors will have the opportunity to examine and evaluate the long-term care benefits being purchased by the association's members and the financial arrangements between the insurer and the association to ensure that they are in the best interest of the members of the association.

Proposed new §3.3849(a) - (d) implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. The provisions in proposed §3.3849(a) - (d) are consistent with the provisions in §23 in the Model Regulations. While §23 of the Model Regulations does not specifically require a certification form, §23C(8) of the Model Regulations includes the requirement that insurers make the annual certification that is proposed in §3.3849(a)(1)(C).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3849 will incur no additional cost as a result of the new requirements. Any such costs incurred by these insurers are the result of legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed requirements.

The Department has determined that it is also necessary to apply the consumer protection requirements in proposed new §3.3849 to insurers, their agents, and associations that market non-partnership long-term care policies, not just partnership policies. The Department has determined that members of associations being solicited for non-partnership policies should receive the same consumer protections as members of associations being solicited for partnership policies. There is no regulatory or public interest reason to exempt association member applicants for non-partnership policies from these consumer protection requirements. In fact, there are significant regulatory and public interest reasons for providing all association member applicants for long-term care coverage the same consumer protections. Providing the same consumer protections to all long-term care association member applicants will mean that that all consumers who are members of associations in Texas will be uniformly protected from unscrupulous or dishonest marketing practices that can cause economic harm to the consumers.

Those insurers that currently write or that opt to write non-partnership long-term care policies and are therefore required to comply with the proposed amendments to §3.3849 will incur costs related to the following requirements: (i) filing with the Department the non-partnership policy and certificate, a corresponding outline of coverage, and an annual certification of the association's compliance with marketing standards for non-partnership policies and certificates in accordance with the Insurer Certification of Association Marketing Compliance specified in §3.3849(e)(1)(F); and (ii) the filing of advertisements for long-term care non-partnership insurance with the Department in accordance with §3.3838(1). The Department anticipates that the following costs will apply to the filing of the non-partnership policy and certificate and corresponding outline of coverage. These estimates are based on the Department's previous experience. A printed page costs approximately $0.05; an envelope, approximately $0.05 to $0.10 depending on the type used; and postage for mailing, $0.42 for a first class mailing with costs increasing depending on the size of the mailing. The Department estimates that insurers will incur costs for filing the annual certification form, which is approximately one page in length when printed in the minimal required 10-point type size, of approximately $0.52 per certification form ($0.05 for printed one-page form, $0.05 for the envelope, and $0.42 for mailing cost). The total anticipated cost for insurers to file the policy and certificate and corresponding outline of coverage will vary based on the number of pages in the filing. Also, the total anticipated cost for insurers to advertisements will vary based on the number of ads filed during a calendar year and the number of pages in each of those advertisements.

Those associations that provide non-partnership long-term care policy solicitations to their members will incur costs related to the following requirements: (i) the disclosure in any long-term care non-partnership insurance solicitation to its members the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; (ii) a brief description of the process under which the policies and the insurer issuing the policies were selected; (iii) the disclosure to its members of the fact of any interlocking directorates or trustee arrangements between the association and the insurer; and (iv) the review and approval by the association's board of directors of the insurance policies and any compensation arrangements the association has with the insurer. The Department anticipates that the total estimated cost for an association to disclose in any long-term care non-partnership insurance solicitation to its members the required information will probably be a maximum of two additional pages at a cost of approximately $0.05 per printed page; the Department anticipates that postage cost for distributing the solicitation will either not increase or increase minimally because of the additional information to be added to the solicitation as required under proposed §3.3849(c).

Proposed New §3.3860. Proposed new §3.3860, pertaining to Policy Summary Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts that Provide Long-Term Care Benefits, applies to non-partnership long-term care policies only. The section sets forth the delivery and content requirements for the policy summary for non-partnership life insurance policies or annuity contracts that provide long-term care benefits by rider. The proposed requirements do not apply to any long-term care partnership policy. Proposed §3.3860(a) requires the insurer to deliver a policy summary at the time of delivery of the non-partnership life insurance policy or annuity contract. In the case of direct response solicitations, insurers are required to deliver the policy summary upon the applicant's request, but regardless of request, to deliver no later than at the time of the policy or annuity contract delivery. Proposed §3.3860(a)(1) - (5) specify the policy summary content require-

ments: (1) an explanation of how the benefits interact with other components of the policy; (2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefit; (3) any exclusions, reductions, and limitations on benefits; (4) a statement that the long-term care inflation protection option required by §3.3820 (relating to Requirement to Offer Inflation Protection) and the long-term care inflation protection provisions required for partnership policies by §3.3872 (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) are not available under this policy; and (5) if applicable to the policy type, a disclosure of the effects of exercising other rights under the policy; a disclosure of guarantees related to the cost of insurance charges, and a disclosure of current and projected lifetime benefits. Under §3.3860(b), insurers may incorporate the provisions of the policy summary into a basic life insurance illustration that is required to be delivered in accordance with Chapter 21 Subchapter N of Title 28, relating to Life Insurance Illustrations. Proposed §3.3860(c) requires insurers to provide a monthly report to each policyholder any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit by rider, is in benefit payment status. The information to be included in the monthly report is also specified in proposed §3.3860(c): (i) any long-term care benefits paid out during the month; (ii) an explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and (iii) the amount of long-term care benefits existing or remaining.

The anticipated public benefit of §3.3860(a), which specifies the policy summary content requirements, will be more consumers who are informed about the various aspects (including how the different types of benefits interact; the exclusions, reductions, and limitations on the benefits; and the unavailability of the long-term care inflation protection option) of purchasing long-term care coverage through the purchase of a non-partnership life insurance policy or annuity contract that provides the long-term care benefits by rider. This information will assist consumers who are considering the purchase of such policies or annuity contracts to make a decision on whether this type of long-term care coverage is appropriate for them.

The anticipated public benefit of §3.3860(b), which allows insurers to incorporate the provisions of the policy summary into a basic life insurance illustration, is that those consumers who purchase a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider, will only be provided a single summary that includes both the life insurance or annuity contract benefits summary and the long-term care benefits summary. Currently, insureds receive two policy summaries, one for the life insurance or annuity contract benefits and one for the long-term care benefits. The single summary should be easier for insureds because they will only need to keep up with the one summary for the two types of insurance.

The anticipated public benefit of §3.3860(c), which requires insurers to provide a monthly report to each policyholder when the life insurance policy or annuity contract that also provides long-term care benefits is in benefit payment status is that each policyholder will receive in a timely manner important information that will enable the policyholder to more effectively monitor the status of their long-term care benefits. This information will relate to benefits paid out during the month, any policy changes, and the amount of long-term care benefits existing or remaining. The anticipated public benefits are that the monthly report will provide important information to the consumer concerning the interaction of the long-term care benefits with the life insurance benefits. The information provided in the monthly report will assist the policyholder to properly and timely monitor the two different types of benefits. This is important because as the long-term care benefits are paid the death benefit and cash surrender value of the life insurance policy are decreasing, and the timely information will assist the consumer in planning his or her future insurance needs, both for life insurance and long-term care coverage.

Proposed new §3.3860 implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a long-term care policy that is funded by a life insurance policy be consistent with the provisions in §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)). The policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements include the provisions in §6J and §6K of the NAIC Long-Term Care Model Act. Proposed §3.3860 is consistent with the §6J and §6K requirements.

Those insurers that are currently writing or that opt to write non-partnership long-term care policies and are therefore required to comply with proposed new §3.3860 will incur no additional cost as a result of the proposed new section. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new section.

Proposed New §3.3870. Proposed new §3.3870, pertaining to Exchange Requirements for Long-Term Care Partnership Policies, applies only to long-term care partnership policies and specifies the requirements for the exchange of an existing long-term care policy for a new long-term care partnership policy and one-time reporting requirement. Section 3.3870(a) requires any insurer that begins to advertise, market, offer, sell, or issue policies that qualify under the Texas Long-Term Care Partnership Program to offer on a one-time basis to all policyholders and certificate holders that were issued long-term care coverage by the insurer on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate. The insurer is required to offer the option to exchange in writing by December 31, 2009.

Insurers may make the new coverage available by the methods that are specified in §3.3870(b). These methods are: (i) by adding a rider or endorsement to the existing policy; or (ii) by exchanging the existing policy or certificate for a new partnership policy or certificate. Proposed new §3.3870(b)(2)(A) specifies the conditions for exchange for new coverage that has an actuarial value of benefits equal to or lesser than the actuarial value of the benefits of the existing coverage: (i) If the new coverage has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing coverage, based on uniform assumptions as determined on the date of issue for a new insured, the insurer must comply with two requirements (the new policy cannot be underwritten and the rate charged for the new policy must be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy. (ii) If the new coverage has an actuarial value of benefits exceeding the actuarial value of benefits of the existing coverage, based on uniform assumptions, as determined on the date of issue for a new insured, the insurer must comply

with two requirements (the insurer must apply its new business, long-term care underwriting guidelines to the increased benefits only and the rate charged for the new policy must be determined using the method specified in §3.3870(b)(2)(A)(ii) for the existing benefits, increased by the rate for the increased benefits using the current attained age and risk class of the insured for the increased benefits only).

Any exchange of an existing long-term care policy or certificate for a partnership policy or certificate must comply with the requirements specified in §3.3870(c): (i) All offers of policy exchanges must be made on a nondiscriminatory basis. (ii) An exchange offer shall be deferred to all policyholders who are currently eligible for benefits, within an elimination period on a claim, or who would not be eligible to apply for coverage due to issue age limitations under the new policy, until such time when such condition expires. (iii) All rates for exchanges must be in accordance with §3.3831 (relating to Standards and Rates); exchange policies may be underwritten and the premium may be increased in accordance with §3.3831 and subject to §3.3810. (iv) The new coverage offered must be on a currently approved form. (v) In the event of an exchange the insured shall not lose any rights, benefits, or built-up value under the original policy.

The anticipated public benefit resulting from the adoption of §3.3870(a) - (c) is that insureds who currently have non-partnership long-term care policies will have an opportunity to exchange their existing policies for a partnership policy. This will enable Texas residents to purchase long-term care policies that have the advantages of asset disregard and estate recovery benefits, which their existing non-partnership policies do not have. Additionally, §3.3870(a) - (c) provides procedures and guidelines for the exchange of existing long-term care policies for partnership policies. This will provide uniformity in the implementation of such exchanges by insurers that will ensure that all insureds who avail themselves of such exchanges will be treated equally and in accordance with state-mandated guidelines.

Proposed §3.3870(a) - (c) implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires the Commissioner of Insurance, in consultation with the Texas Health and Human Services Commission, to adopt minimum standards for a long-term care benefit plan that may qualify as an approved plan under the partnership for long-term care program. The standards must be consistent with provisions governing the expansion of a state long-term care partnership program established under the federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171). Under §1917(b)(1)(C)(iii)(VII) of the Social Security Act (SSA), as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VII)), policies sold prior to the establishment of the partnership program may be exchanged for partnership policies, but the DRA does not provide any requirements or procedures for such exchanges. Therefore, the terms and requirements of such policy exchanges are left to the discretion of each individual state.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3870(a) - (c) will incur no additional cost as a result of the proposed new subsections. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new subsections.

Proposed new §3.3870(d) provides that policies issued pursuant to this section shall be considered exchanges and not replacements. Additionally, insurers are subject to a one-time reporting requirement under §3.3870(e). Insurers must report exchanges made pursuant to §3.3870 on a one-time basis for the 2009 reporting period (to be reported by June 30, 2010) on the Long-Term Care Insurance Replacement and Lapse Reporting Form specified in §3.3837(a)(2). The anticipated public benefit resulting from the reporting requirements in §3.3870(d) and (e) is that an insurer's replacement data for 2009 will not be artificially inflated by adding the number for the exchanges of existing long-term care policies for partnership into the replacement data. By reporting the exchanges as a separate data element on the 2009 report, confusion will be avoided regarding the insurer's actual number of replacement policies sold. This is important because a higher than normal percentage of replacement policies may indicate market conduct problems, such as misrepresentation or fraud in replacing existing policies. The data will thereby assist the Department in conducting more efficient regulation of long-term care marketing practices and enable the Department to focus market conduct examination resources only on those insurers that truly have a high percentage of replacement policies. The anticipated public benefit from the reporting of the exchange long-term care data will also assist the Department in assessing the progress and effectiveness of the partnership program in Texas. The number of exchange policies will be one factor in this assessment.

While proposed new §3.3870(d) and (e) are not required by SB 22 or the DRA, the Department is proposing these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to obtain information important to monitoring the progress of the Texas partnership program. Pursuant to the Human Resources Code §32.107, the Health and Human Services Commission (HHSC) is required to submit a biennial report to the Legislature on the progress of the partnership program and the HHSC may request information from the Department to prepare this report. Additionally, the requirement that insurers report exchanges as a separate data element and not as part of replacement policy data will provide the Department with a more accurate measure of the actual number of replacement policies for each insurer. The number of replacement policies for an individual insurer may be used to identify problematic market trends that may require corrective measures by the Department.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed §3.3870(d), which provides that long-term care partnership policies issued pursuant to §3.3870 shall be considered exchanges and not replacements, will not incur any additional costs as a result of this proposed provision. However, the Department anticipates the insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed §3.3870(e) will incur minimal costs because of the requirements relating to a one-time reporting requirement in which insurers must report exchanges made pursuant to §3.3870 for the 2009 reporting period (to be reported by June 30, 2010) on the Long-Term Care Insurance Replacement and Lapse Reporting Form specified in §3.3837(a)(2). These additional costs will relate to the following: personnel, computer reprogramming, agent training, and printing and distribution. These actual costs will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and number of forms that are needed. An insurer can calculate its estimated costs based on the company's own operation and needs.

Proposed New §3.3871. Proposed new §3.3871, pertaining to Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies and Certificates, applies only to long-term care partnership policies and specifies the standards and reporting requirements for approved long-term care partnership policies. In addition to the required filing and approval pursuant to §3.3873 of this subchapter (relating to Filing Requirements for Long-Term Care Partnership Policies), any policy or certificate marketed or represented to qualify as a long-term care partnership policy or certificate must comply with the requirements specified in §3.3871(a)(1)(A) - (D): (i) the insured individual must be a resident of Texas when coverage first became effective under the policy, and if the policy or certificate is later exchanged for a different long-term care policy or certificate the individual was a resident of Texas when the coverage under the first policy became effective; (ii) a partnership policy must be a tax qualified policy under the provisions of §3.3847 (relating to Qualified Long-Term Care Insurance Contracts: Prohibited Representations); (iii) the policy is issued with and retains inflation protection coverage which meets the inflation standards based on the insured's attained age; and (iv) the effective date of the partnership policy must be the date that the partnership policy is issued or the date the application for the partnership policy was signed. The anticipated public benefit resulting from proposed §3.3871(a)(1)(A) - (D) will be the establishment of a Partnership Program in Texas in accordance with the DRA and SB 22 enacted by the 80th Legislature. The state Partnership Program is intended to promote consumers' purchase of long-term care insurance from insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased coverage. Adopted by the Texas Health and Human Services Commission, these special rules generally allow the individual to protect assets equal to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries.

Proposed new §3.3871(a)(1)(A), (B) and (C) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Pursuant to §1917(b)(1)(C)(iii)(I), (II) and (IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I), (II), and (IV)), the partnership policy must meet the general requirements of those sections in the DRA. Proposed §3.3871(a)(1)(A), (B) and (C) are consistent with §1917(b)(1)(C)(iii)(I), (II), and (IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I), (II), and (IV)).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3871(a)(1)(A), (B) and (C) will incur no additional cost as a result of the proposed new requirements. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new requirements.

A policy or certificate represented or marketed as a long-term care partnership policy or certificate must be accompanied by a disclosure notice (a representation of which is specified in §3.3871(a)(2)(B)(vii)) that explains the benefits associated with the policy or certificate in accordance with the requirements in §3.3871(a)(2)(A) and (B). While proposed new §3.3871(a)(2)(A) and (B) pertaining to the required disclosure notice are not required by SB 22 or the DRA, the Department is proposing these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to provide necessary information to the insured to protect the insured from inadvertently losing partnership status and to inform the insured of various essential facts relating to the partnership policy. The required disclosure notice, titled "Important Information Regarding the Texas Long-Term Care Insurance Partnership Program," provides essential information to the insured relating to certain disclosures, including: (i) the policy purchased qualifies for the Texas partnership program; (ii) the partnership policy may protect the insured's assets through "asset disregard" under the Texas Medicaid program; (iii) the meaning of "asset disregard" and the fact that the purchase of a partnership policy does not guarantee the ability to disregard assets and does not automatically qualify the insured for Medicaid; (iv) the long-term care policy purchased confers partnership status as of the effective of the policy; (v) what could disqualify one's policy status as a partnership policy; and (vi) how the insured can obtain additional information on the partnership policy program. The notice, which is approximately one and one-half pages long, must be in at least 12-point type and must follow the order of the information presented in §3.3871(a)(2)(B)(vii). The text in the notice is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in §3.3871(a)(2)(B)(vii) if the insurer files the form for review and approval by the Commissioner in accordance with the procedures in §3.3871(a)(2)(B)(iii) and (vi). The anticipated public benefit of this disclosure notice is to ensure that individuals who purchase partnership policies have information in a separate document that accompanies the partnership policy that explains the benefits of the partnership program. Additionally, this notice will also be helpful in notifying family members or others who are administering the estate of the insured of the partnership status of the policy and of the estate recovery exemptions available for benefits paid under a partnership policy. The anticipated public benefit of the requirements and procedures related to the disclosure notice are: (i) the 12-point type requirement will assist the consumer to more easily read and comprehend the information in the notice; and (ii) while the text and order of presentation of the information in the forms is mandated by the DRA, insurers will have flexibility with regard to the formatting of the forms subject to Department approval.

Proposed new §3.3871(a)(2)(B)(ix) requires that when an insurer is made aware that a policyholder has initiated an action that will result in the loss of partnership status, the insurer must advise the policyholder in writing of how to retain the partnership status if possible. Proposed new §3.3871(a)(2)(B)(x) requires that when a partnership plan loses partnership status, the insurer must explain in writing to the policyholders the reason for the loss of status. While proposed new §3.3871(a)(2)(B)(ix) and (x) are not required by SB 22 or the DRA, the Department is proposing these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to provide important information to the insured to enable the insured to retain the partnership status of the policy if possible and to explain to the insured why there has been a loss of partnership status. The anticipated public benefit is that these provisions will help to protect the insured from inadvertently losing partnership status and will provide vital information to the insured concern-

ing any loss of partnership status by the insurer. Because of the important benefits of a partnership long-term care policy, including the advantages of asset disregard and estate recovery benefits, it is in the insured's interest to be informed about any possible loss of the partnership status of the long-term care policy. With this information, the insured may have the opportunity to take steps to either prevent the loss of partnership status or to replace the policy that has lost partnership status with another partnership policy.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with the proposed requirements in new 3.3871(a)(2)(A) and (B) will incur costs relating to: (i) the printing and distribution of the required disclosure notice Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates specified in §3.3871(a)(2)(B)(vii); (ii) the printing and distribution of the written explanation required to be sent to the insured when an insurer becomes aware that an insured has initiated action that will result in the loss of partnership status and a written explanation of how such action impacts the insured in writing; and (iii) the printing and distribution of an explanation advising the insured on how to retain partnership status if possible. The Department anticipates that the required disclosure notice Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates will be approximately one and one-half pages in length if printed in the minimum permissible 12-point type; that the written explanations concerning loss of partnership status and how such action impacts the insured in writing will be approximately one to one and one-half pages in length; and the explanation on how to retain partnership status will be approximately one page in length. Based on the Department's experience, a printed page costs approximately $0.05 per page. Therefore, it is anticipated that insurers that print the required disclosure notice Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates will incur approximately $0.10 per notice. It is anticipated that insurers that print the written explanations concerning loss of partnership status and how such action impacts the insured will incur approximately $0.10 per notice. And insurers that print the explanation on how to retain partnership status will incur approximately $0.05 per notice. Mailing costs for each of the required notices will be approximately $0.42 per notice. The Department anticipates that total estimated costs will depend on several factors, including how many notices are required to be sent, the type of office equipment that is used (including computers, printers, and copiers), the size of the insurer, and salaries of personnel required to prepare the notices.

Proposed new §3.3871(b) specifies new reporting requirements for insurers that issue partnership policies. In accordance with §1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VI) and (v)), all issuers of partnership policies or certificates must provide regular reports to the Secretary of the Department of Health and Human Services (Secretary) in accordance with regulations to be developed by the Secretary. As provided under proposed §3.3871(b)(1) - (3), such information shall include but not be limited to the following: (i) notification of when insurance benefits provided under a partnership policy have been paid and the amount of such benefits, (ii) notification regarding when such policies terminate, and (iii) any other information the Secretary determines is appropriate. Proposed new §3.3871(b) implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Section 1917(b)(1)(C)(iii)(VI) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(VI)) includes the requirements that are proposed in §3.3871(b). The anticipated public benefit resulting from this proposed new §3.3871(b) will be Department rules that are consistent with the reporting requirements for insurers that issue long-term care partnership policies. The information that insurers report to the Secretary of Health and Human Services will enable the Secretary to monitor the partnership program in Texas in accordance with the insurer reporting requirements established under the DRA.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3871(b) will incur no additional cost as a result of the proposed new requirements. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new requirements.

Proposed New §3.3872. Proposed new §3.3872, pertaining to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates, specifies the inflation protection requirements for long-term care partnership policies and certificates. Under proposed §3.3872(1), a policy or certificate must provide, for a person who is less than 61 years of age as of the date of purchase, compound annual inflation protection from the date of purchase until the person attains age 61. An insurer is required under proposed §3.3872(1)(A) to offer to each applicant at the time of purchase the option to purchase compound annual inflation protection that automatically increases each year on a compounded basis at a rate of not less than 5.0 percent annually throughout the interval of coverage; the inflation protection is required to automatically increase benefits each year on a compounded basis. Proposed §3.3872(1)(B) specifies that if the applicant declines the offer of not less than 5.0 percent compound annual inflation protection, then the insurer must offer and the applicant must purchase and retain compound annual inflation protection until the insured attains age 61 or goes on claim status, whichever comes first. The inflation protection is required to automatically increase benefits each year on a compounded basis at a rate that the insured elects which may be in a range of from one percent to four percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U). Proposed new §3.3872(1)(C) specifies that a person who is less than 61 years of age who has purchased a long-term care partnership policy or certificate with the required compound inflation protection may upon attaining 61 years of age choose to amend the compound inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(2). Proposed new §3.3872(2) specifies that for a person who is between 61 and 76 years old, the policy must provide some acceptable level of inflation protection until the person attains 76 years of age. Proposed paragraph (2)(A) specifies that regardless of the insured's health status the insurer must offer inflation protection and the insured must accept and retain inflation protection until the insured attains age 76 or goes on claim status. Proposed §3.3872(2)(A) - (D) specify that acceptable inflation protection includes: (i) regardless of the insured's health status, the insurer must offer and the insured must purchase and retain inflation protection until the insured attains age 76 or goes on claim status, whichever comes first; (ii) automatic annual inflation protection, either simple or compound, paid with either level or stepped

premium; (iii) the Inflation protection may be in a range of from one percent to five percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U); and (iv) a person who is less than 76 years of age who has purchased a long-term care partnership policy or certificate with the required inflation protection may upon attaining 76 years of age choose to amend the inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(3). Proposed new §3.3872(3) specifies that for a person who is 76 years old, inflation protection may be provided but is not required. Proposed new §3.3872(4) specifies that an option to purchase inflation protection in the future does not constitute compliance with the requirements in §3.3872(1) and (2). Proposed new §3.3872 implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. The DRA in §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) includes the requirements that are proposed in §3.3872. The anticipated public benefit resulting from these inflation protection requirements will be that policyholders will be provided protection from escalating long-term care cost by increasing policy benefits each year in accordance with a fixed percentage or in accordance with the flexible measure of inflation (CPI-U).

Proposed new §3.3872 implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Pursuant to §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)), the partnership policy must meet the general requirements of this section in the DRA. Proposed §3.3872 is consistent with §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)).

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3872 will incur no additional cost as a result of the proposed inflation protection requirements. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new section.

Proposed New §3.3873. Proposed new §3.3873(a), pertaining to Filing Requirements for Long-Term Care Partnership Policies, specifies the prior approval requirements that apply to any partnership policy, certificate, or endorsement that is to be delivered or issued for delivery in this state. Under proposed §3.3873(a)(1), each such partnership policy, certificate, or endorsement must be filed with the Department and approved in accordance the procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings). Proposed new §3.3873(a)(2) requires that each partnership policy, certificate, or endorsement filing must include the Long-Term Care Partnership Program Insurer Certification Form specified in §3.3873(a)(2)(F). Proposed new §3.3873(a)(2)(A) - (F) specify the requirements and procedures that apply to the Insurer Certification Form, including text content and font size, order of information presented, format requirements, and filing and approval requirements if applicable. The proposed certification form specifies the elements of information that are required to be provided to the Department by each insurer for each partnership policy, certificate, or endorsement that is filed by the insurer for approval by the Commissioner for use under the Qualified Partnership Program. Pursuant to §1917(b)(5)(B)(iii) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(B)(iii)), the Commissioner of Insurance, when implementing a qualified state long-term care insurance partnership program, is authorized to certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)) and principally include certain specific provisions of the 2000 NAIC Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act. The certification form to be filed by the insurer requests information relating to: (i) in Section I, general information relating to the insurer's name and address, a contact person for information relating to the filing, the policy form number(s) or other identifying information; for a policy form not previously approved, copies of the policy forms including any riders or endorsements must be included; and for a policy form previously approved, only identifying policy information must be included; (ii) in Section II, the insurer's response regarding whether the specified requirements of the Model Regulations and Model Act are met with respect to all policies and certificates that are intended to be included under the Qualified Partnership Program; and (iii) in Section III, the insurer's certification to the Commissioner that all of the attached or identified policy forms, riders and endorsements meet all of the requirements of the Model Regulations and Model Act that are specified in the Federal Deficit Reduction Act of 2005 and that all of the answers, accompanying information, and other information contained in the certification form are true, correct and complete.

Proposed new §3.3873(b) sets forth the requirements and procedures for the filing of a policy, certificate, or endorsement that has not been previously approved by the Commissioner. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the proposed requirements in §3.3873(b)(1) - (4), including: (i) the policy, certificate, or endorsement must be filed with the Department and approved by the Commissioner, and Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form must be submitted for each policy, certificate, or endorsement form submitted for partnership approval; (ii) the policy, certificate, or endorsement form must be in at least 10-point type; (iii) the policy form filing must be filed at least 60 days prior to use and is subject to the requirements and procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements For Filings and Departmental Actions Related to Such Filings); and (iv) and any policy form filing should be filed with the Filings Intake Division of the Texas Department of Insurance.

Proposed new §3.3873(c) specifies the requirements and procedures for insurers requesting to use a previously approved non-partnership long-term policy as a long-term care partnership policy. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the proposed requirements in §3.3873(c)(1) - (6),

including: (i) the insurer must file Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form and a copy of any endorsement that is needed to comply with the partnership policy requirements; (ii) the policy form numbers or other identifying information must be included on Form Number LHL570(LTC); (iii) the filing must be approved by the Commissioner prior to the use of the form as a partnership policy; (iv) a previously approved policy or certificate does not have to be included in the filing; (v) the filing made must be made at least 60 days prior to use and is subject to the procedures in Chapter 3, Subchapter A of this title (relating to Submission Requirements For Filings and Departmental Actions Related to Such Filings); and (vi) the filing should be submitted to the Filings Intake Division of the Texas Department of Insurance.

The anticipated public benefit resulting from these proposed requirements will be to provide efficient, well defined procedures for insurers to file their partnership policies for approval with the Department. Additionally, the proposed section provides an efficient certification procedure for insurers to certify to the Commissioner that their policies meet all of the consumer protection requirements specified in the DRA. This will ensure that Texas consumers are offered and provided the opportunity to purchase only those long-term care partnership policies that have been approved by the Commissioner as meeting all of the consumer protection requirements specified in the DRA.

Proposed new §3.3873 implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. The DRA in §1917(b)(5)(B)(iii) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(B)(iii)) authorizes the Insurance Commissioner of a state implementing a qualified state long-term care insurance partnership ("Qualified Partnership") to certify to the state Medicaid agency that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. Proposed §3.3873, including the information to be provided in the proposed Long-Term Care Partnership Program Insurer Certification Form, are necessary to provide the Commissioner of Insurance with the information necessary to provide a certification for the policies.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3873 will incur no additional cost as a result of the proposed new section. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new section.

Proposed New §3.3874. Proposed new §3.3874, pertaining to Insurer Requirements for Agents That Market Partnership Policies and Certificates, specifies insurer requirements for reporting information to the Department on agents that market long-term care partnership plans. Proposed new §3.3874(a)(1) - (3) specify training verification and certification requirements for insurers with agents who market partnership plans. These proposed requirements are: (i) obtaining of verification that an agent has received the training specified in §19.1022 of this title (relating to Long-Term Care Partnership Certification Course); (ii) insurer certification to the Commissioner that each agent who sells partnership policies or certificates on behalf of the insurer complies with the training requirements of this subsection; and (iii) insurer's maintenance of verification records for at least four years; records are subject to review by the Department or its designee at any time. The initial certification (for the period from the effective date of the rules to January 31, 2009) must be submitted on the Initial Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(A). Any subsequent certification must be submitted on the Annual Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(B).

Proposed new §3.3874(b) specifies the requirements and procedures that apply to the proposed Initial Training Certification Form and the Annual Training Certification Form, including text content, text font size, recommended format, and filing and approval requirements and procedures as applicable.

Proposed new §3.3874(c)(1) - (3) specifies the filing requirements for the agent training certification by each insurer. An insurer offering partnership policies or certificates must submit: (i) the Initial Long-Term Care Partnership Agent Training Certification Form for the initial certification, and (ii) the Annual Long-Term Care Partnership Agent Training Certification Form for each subsequent annual certification. The Initial Training Certification Form is to be used for certification by the insurer for the initial certification period (from the effective date of the rules to January 31, 2009). This form will be used by the insurer to certify that each individual who is currently selling partnership policies has completed training and demonstrated evidence of understanding long-term care partnership policies. There will be a grace period from the effective date of the rules to January 31, 2009, during which agents who have a license to sell accident and health insurance but may not have completed the specialized partnership training will be eligible to sell partnership policies. Insurers will file the Annual Training Certification annually with the Department beginning in January 2010 to certify that each individual who currently sells partnership policies for the insurer has completed the required training before the agent sells or solicits the insurer's partnership products.

The anticipated public benefit resulting from these proposed reporting requirements will be that insurers will have to certify to the Department that all agents who are marketing long-term care partnership policies have adequate training and understanding of these policies and how they relate to other public and private coverage of long-term care so that the agents are better able to adequately explain the coverage to applicants. This, in turn, should result in more consumers in Texas being aware of the information that is necessary to assist them in determining whether to purchase long-term care insurance. Proposed new §3.3874 implements the provision of SB 22, codified as Insurance Code §1651.104 and §1651.105. Section 1651.104 requires a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Section 1651.105 requires that each long-term care benefit plan issuer that offers a plan under the partnership for long-term care program shall certify to the Commissioner, in the form required by the Commissioner that each individual who sells on behalf of the issuer has complied with the training requirements of §1651.105(a). The DRA in §1917(b)(1)(C)(iii)(V) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(V)) and §1651.105 of the Insurance Code include the requirements that are proposed in §3.3874.

Those insurers that opt to write partnership long-term care policies and are therefore required to comply with proposed new §3.3874 will incur no additional cost as a result of the new requirements. Any such costs incurred by these insurers are the result of the legislative enactment of SB 22 and the DRA and are not the result of the adoption, enforcement, or administration of the proposed new section.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.

Insurers That Opt to Write Partnership Long-Term Care Policies. As required by the Government Code §2006.002(c), the Department has determined that there are no insurers currently writing long-term care insurance in Texas and that could opt to write partnership long-term policies that qualify as small or micro businesses under the Government Code §2006.001. Additionally, the Department has determined that long-term care insurance is a capital intensive line of insurance and the Department does not anticipate that small or micro insurers will enter this market. However, as required by the Government Code §2006.002(c), the Department has determined that the proposed requirements will not have an adverse economic impact on these small or micro businesses that opt to write partnership policies. The Department has made this determination based on the following factors.

No insurer is required by law to write long-term care partnership insurance. The proposed rules, however, provide insurers an economic opportunity to engage in the long-term care partnership insurance market in Texas. The Department's analysis of any possible costs for compliance with the requirements for insurers writing partnership policies are detailed in the Public Benefit/Cost Note section of this proposal and apply to insurers that opt to utilize this opportunity.

As indicated in the Public Benefit/Cost Note analysis, those insurers that opt to write long-term care partnership policies pursuant to the Insurance Code Chapter 1651 Subchapter C and are therefore required to comply with the following proposed amendments and new sections will incur no additional costs as a result of the amendments and new sections because the amendments and new sections are the result of the legislative enactment of SB 22, and/or the federal Deficit Reduction Act of 2005 (DRA) (Pub. L. No. 109-171), and not from the adoption, enforcement, or administration of proposed §3.3826(a) and (b) relating to limitations and exclusions; 3.3829(b)(2), (b)(8), and (b)(9) relating to required disclosures; §3.3830(h) relating to requirements for application forms and replacement coverage; §3.3837(a) - (g) relating to reporting requirements; §3.3838(1) relating to filing requirements for advertising; §3.3839(a)(8) - (11) relating to standards for marketing; §3.3842(b) - (j) relating to appropriateness of recommended purchase (suitability standards); §3.3844(e), (e)(3), (g)(2), and (g)(4) relating to relating to nonforfeiture and contingent benefits; new §3.3848(a) - (b) relating to requirements for limited premium payment options in long-term care policies, certificates, and riders; new §3.3849(a) - (e) relating to requirements for insurers that issue long-term care policies to associations and marketing standards for association that market the policies; new §3.3870(a) - (e) relating to exchange requirements for long-term care partnership policies; new 3.3871(a) - (b) relating to standards and reporting requirements for approved long-term care partnership policies; new 3.3872 relating to inflation protection requirements for long term care partnership policies and certificates; new 3.3873(a) - (c) relating to filing requirements for long term care partnership policies; and new 3.3874(a) - (c) relating to insurer requirements for agents that market long term care partnership policies and certificates.

In accordance with the Government Code §2006.002(c), the Department has therefore determined that a regulatory flexibility analysis is not required because the proposal will not have an adverse impact on these small or micro businesses.

Insurers Currently Writing Non-Partnership Long-Term Care Policies or That Opt to Write Non-Partnership Long-Term Care Policies in the Future.

As required by the Government Code §2006.002(c), the Department has determined that there are no insurers currently writing long-term care non-partnership insurance in Texas that qualify as small or micro businesses under the Government Code §2006.001. No insurer is required by law to write long-term care non-partnership insurance. The proposed rules, however, provide insurers an economic opportunity to engage in the long-term care non-partnership insurance market in Texas. As required by the Government Code §2006.002(c), the Department has determined that the proposal may have an adverse economic effect on those small or micro businesses that opt to utilize such an opportunity. Adverse economic impact may result from costs relating to personnel, computer reprogramming, agent training, and printing and distribution costs that are associated with the insurer's compliance with the new consumer protection requirements for non-partnership policies. The Department's cost analysis and resulting estimated costs in the Public Benefit/Cost Note portion of this proposal is equally applicable to these small or micro businesses. The Public Benefit/Cost Note portion of this proposal indicates in a section by section analysis the amount of potential new costs that may be associated with the insurer's compliance with the new consumer protection requirements for non-partnership policies. The actual costs incurred will vary based on several factors that pertain to each individual insurer, including the size of the insurer; type of office equipment, including printers and computers; employee salaries; and the number of forms that are needed.

In accordance with the Government Code §2006.002(c-1), the Department has determined that even though proposed §3.3826(a) and (b) relating to limitations and exclusions; 3.3829(b)(2), (b)(8), and (b)(9) relating to required disclosures; §3.3830(h) relating to requirements for application forms and replacement coverage; §3.3837(a) - (g) relating to reporting requirements; §3.3838(1) relating to filing requirements for advertising; §3.3839(a)(8) - (11) relating to standards for marketing; §3.3842(b) - (j) relating to appropriateness of recommended purchase (suitability standards); §3.3844(e), (e)(3), (g)(2), and (g)(4) relating to relating to nonforfeiture and contingent benefits; and proposed new §3.3848(a) - (b) relating to requirements for limited premium payment options in long-term care policies, certificates, and riders; new §3.3849(a) - (e) relating to requirements for insurers that issue long-term care policies to associations and marketing standards for association that market the policies; and new §3.3860 relating to policy summary requirements for life insurance policies that provide long-term care benefits may have an adverse economic effect on small or micro-businesses that are required to comply with these proposed requirements, the Department is not required to prepare a regulatory flexibility analysis as required in §2006.002(c)(2) of the Government Code. Section 2006.002(c)(2) requires a state agency, before adopting a rule that may have an adverse economic effect on small businesses, to prepare a regulatory

flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Section 2006.002(c-1) of the Government Code requires that the regulatory flexibility analysis "consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses." Therefore, an agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and micro-businesses, would not be protective of the health, safety, and environmental and economic welfare of the state.

The Legislature in SB 22, codified as §1651.104 directs the Commissioner to "adopt minimum standards for a long-term care benefit plan that may qualify as an approved plan under the partnership for long-term care program. The standards must be consistent with provisions governing the expansion of a state long-tern care partnership program established under the federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171)." The minimum standards for the partnership program are the new consumer protection requirements that are also being applied to non-partnership policies.

The proposal applies the minimum standards of the partnership program, which are the new consumer protection requirements contained in the proposal, to non-partnership long-term care policies. The new consumer protection requirements that are being applied to non-partnership policies are contained in the amended and new sections as follows: §3.3826(a) and (b); §3.3829(b)(2), (b)(8), and (b)(9); §3.3830(h); §3.3837(a) - (g); §3.3838(1); §3.3839(a)(8) - (11); §3.3842(b) - (j); §3.3844(e), (e)(3), (g)(2), and (g)(4); new §3.3848(a) - (b); new §3.3849(a) - (e); and new §3.3860. The Department has determined that individuals being solicited for non-partnership policies should receive the same consumer protections as individuals being solicited for partnership policies.

Some of the most important new consumer protection requirements that are being applied to non-partnership policies are those that relate to an applicant's suitability to purchase long-term care insurance. These new suitability requirements form a comprehensive regulatory scheme for determining an applicant's suitability to purchase long-term care insurance. Each issuer must develop and use suitability standards to determine whether the purchase or replacement of long-term care is appropriate to the needs of the applicant and train its agents in the use of the issuer's suitability standards. The new consumer protection provisions require the issuer to develop suitability procedures to determine whether the applicant meets the issuer's suitability standards. These procedures must consider the following factors: the applicant's ability to pay for the proposed coverage and other pertinent financial information; the applicant's goals and needs with respect to long-term care; and the values, benefits, and costs of the applicant's existing insurance as compared to the values, benefits, and costs of the recommended purchase or replacement. Additionally, the new consumer protection provisions require the issuer to make reasonable efforts to obtain the information specified in a new form titled the Long-Term Care Personal Worksheet. The Long-Term Care Personal Worksheet requires the issuer to obtain detailed information from any individual who is considering the purchase of a long-term care policy. Such information includes the applicant's current insurance and premium payments, the applicant's income and net worth, the issuer's rate history, and also a disclosure of the issuer's right to increase premiums. The public benefit resulting from the use of this new form is that the additional information obtained from the applicant on the Personal Worksheet will assist the issuer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. The public benefit resulting from the proposed new consumer protection requirements will be more purchasers of long-term care insurance who are financially and otherwise suitable to make such a purchase. The new requirements require issuers to use objective measures to evaluate an applicant's suitability to purchase long-term care insurance by collecting detailed information regarding the applicant's assets, current insurance in-force, and the applicant's probable future insurance needs. This information is to be carefully evaluated by the issuer in light of the issuer's established suitability standards to ensure that each individual who purchases long-term care insurance is financially suitable to make such a purchase and that the product purchased is suitable to the individual's needs and goals.

Additionally, the new suitability provisions require issuers to provide to the applicant at the same time the Personal Worksheet is provided the proposed new disclosure form titled Things You Should Know Before You Buy Qualified Long-Term Care Insurance. This form provides important information to the consumer concerning the general functions of a long-term care insurance policy, Medicare and Medicaid as those programs relate to long-term care insurance, the availability of a Shopper's Guide for Long-Term Care, the availability of a senior health insurance counseling program, and general information concerning long-term care facilities. This disclosure form is intended to help the applicant decide whether it is prudent to purchase a long-term care policy.

The new consumer protection provisions relating to suitability further address actions to be taken if the issuer determines that the applicant does not meet its financial suitability standards or if the applicant has declined to provide the requested information. If either of these events occur, the issuer may either reject the application or, if the issuer does not opt to reject the application, the issuer is required to send the applicant a letter in accordance with the proposed new Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. The letter will inform an applicant that the issuer has reviewed the financial information provided by the applicant on the Personal Worksheet and has determined that the applicant is not financially suitable to purchase long-term care insurance and that review of the application has been suspended or that the applicant has not provided any or has provided insufficient financial information for the issuer to make a determination as to the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended. The public benefit resulting from the use of the Suitability Letter is that applicants will receive important information concerning the status of their application. This information will indicate either that the issuer has determined that the applicant is not financially suitable to purchase long-term care insurance or that the financial information provided by the applicant is not sufficient for the issuer to

make a determination regarding the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended. The Suitability Letter will further inform the applicant that the applicant may choose to continue the application process despite the determination that long-term care may not be a suitable purchase. This information is important because it alerts a consumer to the fact that their application for a long-term care policy is no longer being processed unless the consumer chooses to proceed with the purchase.

The new consumer protection provisions require the dissemination of a new form titled The Long-Term Care Insurance Potential Rate Increase Disclosure Form to the applicant at the time of application or enrollment. The Long-Term Care Insurance Potential Rate Increase Disclosure Form provides detailed information to the applicant concerning the potential for a rate increase prior to the applicant purchasing a long-term care policy. The Long-Term Care Potential Rate Increase Disclosure Form requires the insurer to provide detailed information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policy options in the event of a rate increase. The public benefit resulting from the use of this new form is that the information provided to the applicant regarding potential rate increases on the Potential Rate Disclosure Form will assist the applicant in making an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This will ensure that those consumers who do not need or cannot afford such a policy will be less likely to purchase one.

The foregoing discussion of the suitability consumer protection provisions is not exhaustive of the new consumer protection requirements but it is clearly representative of the type and complexity of the regulatory scheme being proposed in these rules. The new consumer protection suitability requirements are protective of the health, safety, and economic welfare of the state because applying such standards will protect the members of this vulnerable group of consumers from purchasing long-term care insurance if they are not financially suitable to purchase such products. There are no alternative methods of achieving the consumer protection purposes of this rule due to the very complex and comprehensive nature of this regulatory scheme.

There is no regulatory or public interest reason to exempt individuals being solicited for non-partnership policies from these consumer protection requirements. In fact, there are significant regulatory and public interest reasons for providing all individuals being solicited for long-term care coverage the same consumer protections. Providing the same consumer protections to all individuals being solicited for long-term care means that that all consumers who are being solicited for long-term care insurance in Texas will be uniformly protected from unscrupulous or dishonest marketing practices that can cause economic harm to the consumers. The application of these new consumer protection requirements to non-partnership insurance solicitations is a vital part of the regulatory system that is designed to protect consumer economic interests and the state's welfare. These requirements collectively ensure that consumers who are being solicited for non-partnership long-term care insurance are also being afforded the entire panoply of consumer protections that are available to partnership solicitations.

Therefore, the Department has determined, in accordance with §2006.002(c-1) of the Government Code, that because the purpose of proposed §3.3826(a) and (b); §3.3829(b)(2), (b)(8), and (b)(9); §3.3830(h); §3.3837(a) - (g); §3.3838(1); §3.3839(a)(8) - (11); §3.3842(b) - (j); §3.3844(e), (e)(3), (g)(2), and (g)(4); new §3.3848(a) - (b); new §3.3849(a) - (e); and new §3.3860 is to protect consumer economic interests and the state's welfare, there are no additional regulatory alternatives to the required comprehensive consumer protection requirements that will sufficiently protect the economic interests of consumers and the welfare of the state.

TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on August 18, 2008, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Ana Smith-Daley, Deputy Commissioner of the Life and Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will consider the adoption of amendments to §§3.3801 - 3.3804, 3.3821, 3.3826, 3.3829, 3.3830, 3.3833, 3.3834, 3.3837 - 3.3839, 3.3842, 3.3844 - 3.3846 and new 3.3848, 3.3849, 3.3860. and 3.3870 - 3.3874 in a public hearing under Docket Number 2689 scheduled for 9:30 a.m.. on August 18, 2008, in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Written and oral comments presented at the hearing will be considered.

DIVISION 1. GENERAL PROVISIONS

28 TAC §§3.3801 - 3.3804

STATUTORY AUTHORITY. The amendments are proposed pursuant to the Insurance Code §§1651.004, 1651.101 - 1651.107, and §36.001 and §1917(b) of the Social Security Act (SSA) as amended by §6021 of the Deficit Reduction Act of 2005 (DRA) (pertaining to Expansion of State Long-Term Care Partnership Program) (42 U.S.C. §1396p(b)). Section 1651.004 provides that the Department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651 concerning long-term care benefit plans. SB 22 enacted by the 80th Legislature, Regular Session, effective March 1, 2008, amended Chapter 1651 to add new Subchapter C concerning the Partnership for Long-Term Care Program. Section 1651.101 specifies the definitions that are specific to the Texas partnership program. Section 1651.102 specifies the applicability of Subchapters A (General Provisions) and B (Benefit Plan Standards), which were in effect prior to the enactment of SB 22, to the partnership policies issued in accordance with new Subchapter C. Section 1651.103 requires that the Department assist the Health and Human Services Commission as necessary for the Commission to perform its statutorily specified partnership program duties and functions, as provided in Chapter 32 Subchapter C. of the Human Resources Code. Section 1651.104 requires the Department to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that qualifies as an approved plan under the partnership program and further requires that the standards be consistent with the provisions of the federal DRA. Section 1651.105 requires that each individual who sells a partnership

policy must complete training and demonstrate an understanding of how partnership policies relate to other public and private coverage of long-term care and requires each insurer that offers partnership policies to certify to the Commissioner that its agents who sell partnership policies comply with the required training requirements. Section 1651.106 provides that, if the partnership program is discontinued, an individual who has purchased a partnership policy remains eligible to receive the benefits under the partnership policy. Section 1651.107 authorizes the Commissioner to adopt rules as necessary to implement Subchapter C. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The federal enabling legislation regulating qualified partnerships was enacted in the DRA of 2005; it was signed into law on February 8, 2006. Section 6021(a)(1)(A) of the DRA, expands State Long-Term Care Partnership Programs, which encourage individuals to purchase long-term care insurance. State partnership programs are intended to promote consumers' purchase of long-term care insurance from private insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased partnership coverage. The DRA amends §1917(b)(1)(C) of the Social Security Act by adding new clause (iii) to permit states to exempt long-term care benefits from estate recovery, if the state has a state plan amendment filed with and approved by the Department of Health and Human Services Center for Medicaid and Medicare Services that provides for a qualified state long-term care insurance partnership. Additionally, §6021(a)(1)(A) of the DRA enacts several new provisions codified at §1917(b)(1)(C) of the Social Security Act that specify the requirements for partnership policies, including: (i) §1917(b)(1)(C)(iii)(II) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(II)) specifies that the policy must be a qualified long-term care insurance contract as defined in §7702B(b) of the Internal Revenue Code, (ii) §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)) specifies that the policy must meet the consumer protection requirements in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)) which include meeting the requirements of specific portions of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulations and Model Act, (iii) §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must be issued not earlier than the effective date of the Qualified Partnership, (iv) §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) specifies that the policy must include inflation protection in accordance with the DRA, and (v) §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must cover an insured who is a resident of the state when the coverage first became effective.

CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal: Insurance Code §1651.004 and §1651.104

§3.3801. Authority.

This subchapter of rules [~~and regulations~~] of the Texas Department of Insurance is promulgated and adopted pursuant to the authority vested in the commissioner under the Insurance Code Chapter 1651 and §36.001 [~~, Article 1.03A and Article 3.70-12~~].

§3.3802. Purpose.

The purpose of this subchapter is to implement the Insurance Code Chapter 1651: [~~, Article 3.70-12,~~]

(1) to promote the public interest; [~~,~~]

(2) to promote the availability of long-term care insurance coverage; [~~,~~]

(3) to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices; [~~,~~]

(4) to facilitate public understanding and comparison of long-term care insurance coverages; [~~,~~]

(5) to facilitate flexibility and innovation in the development of long-term care insurance; [~~, and~~]

(6) to allow the sale of long-term care insurance contracts which will qualify insureds, under certain conditions, for favorable tax treatment under federal law; and

(7) to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that may qualify as an approved plan under the long-term care partnership program.

§3.3803. Applicability and Severability [~~Scope~~].

(a) Applicability.

(1) In accordance with the Insurance Code Chapter 1651, §§3.3801 - 3.3804 of this subchapter (relating to General Provisions) apply to all long-term care insurance coverage that is regulated under this subchapter.

(2) In accordance with the Insurance Code Chapter 1651 [~~Article 3.70-12~~], §§3.3805 - 3.3849 of this subchapter (relating to Non-partnership and Partnership Long-Term Care Insurance) apply [~~applies~~] to all non-partnership and partnership long-term care benefit plans [~~insurance policies~~] as that term is defined in the Insurance Code §1651.003 and §3.3804 of this subchapter (relating to Definitions) [~~§2(4) of the article~~], and long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates delivered or issued for delivery in this state except as specified in paragraph (5) of this subsection. [~~:~~]

(3) In accordance with the Insurance Code Chapter 1651 Subchapter C (relating to Partnership for Long-Term Care Program), §3.3860 of this subchapter (relating to Policy Summary Requirements for Non-partnership Life Insurance Policies and Annuity Contracts that Provide Long-Term Care Benefits) applies only to non-partnership life insurance policies that provide long-term care benefits by rider except as specified in paragraph (5) of this subsection.

(4) In accordance with the Insurance Code Chapter 1651 Subchapter C, §§3.3870 - 3.3874 of this subchapter (relating to Partnership Long-Term Care Insurance Only) apply only to long-term care partnership benefit plans as that term is defined in the Insurance Code §1651.101 and §1651.104 delivered or issued for delivery in this state except as specified in paragraph (5) of this subsection.

(5) In accordance with the Insurance Code §1651.002, this subchapter does not apply to:

(A) [~~(1)~~] certificates delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state; or

(B) [~~(2)~~] a policy or certificate that [~~which~~] is not designed, advertised, marketed, or offered as long-term care or nursing home insurance.

(b) Severability. If any provision of the sections in this subchapter or its application to any person or circumstance is held to be invalid, such invalidity shall not affect other provisions or applications which can be given effect without the invalid provisions, and to this end, the provisions of each section are declared to be severable.

§3.3804. Definitions.

(a) (No change.)

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (13) (No change.)

(14) Group long-term care insurance--A long-term care insurance policy or certificate of group long-term care insurance that [~~which~~] is delivered or issued for delivery in this state[~~,~~] and issued to an eligible group as defined by the Insurance Code Chapter 1251 Subchapter B (relating to Group Accident Health Insurance: Eligible Policyholders) but subject to the exemptions in the Insurance Code §1651.002 (relating to Exemptions) [~~Article 3.51-6, §1(a)~~], or a long-term care rider issued to an eligible group as defined by the Insurance Code §1131.002 (relating to Certain Group Life Insurance Authorized) [~~Article 3.50 §1~~].

(15) - (18) (No change.)

(19) Long-term care benefit plan--An insurance policy or group certificate, or rider to the policy or certificate, or evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Insurance Code Chapter 843) that is advertised or marketed as providing, or offered or designed to provide, coverage for not less than 12 consecutive months for each covered individual on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital. The term includes a plan or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or for the loss of functional capacity. The term does not include an insurance policy, group certificate, or evidence of coverage that is offered primarily to provide Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage or basic or single health care services.

(20) [~~(19)~~] Long-term care insurance [~~contract~~]--Any insurance policy, group certificate, rider to such policy or certificate, or evidence of coverage that [~~issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Texas Insurance Code, Chapter 20A) which~~] is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, per diem or other basis[~~, and which provides insurance protection only~~] for one or more necessary or medically necessary services of the following types, administered in a setting other than an acute care unit of a hospital: diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance, or personal care. The term includes riders for group and individual annuities and life insurance policies that provide long-term care insurance. The term also includes a policy, certificate, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; and health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. The term "long-term care insurance [~~contract~~]" shall not include any insurance policy, group certificate, subscriber contract, or evidence of coverage that [~~which~~] is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or asset-related protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision of this subchapter, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this subchapter. [~~The term includes a policy or rider, other than a group or individual annuity or life insurance policy that provides for payment of benefits based on the impairment of cognitive ability or the loss of functional capacity.~~]

(21) Long-term care partnership insurance contract--A long-term care insurance contract established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171 and Chapter 1651 Subchapter C of the Insurance Code.

(22) [~~(20)~~] Maintenance or Personal Care Services--Any care the primary purpose of which is the provision of needed assistance under §3.3818 of this subchapter [~~title~~] (relating to Standards for Eligibility for Benefits), including the protection from threats to health and safety due to impairment of cognitive ability.

(23) [~~(21)~~] Medicare--"The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(24) [~~(22)~~] Mental or Nervous Disorder--A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(25) [~~(23)~~] Policy--Any policy, contract, subscriber agreement, rider, or endorsement, delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit group hospital service corporation, or health maintenance organization subject to the Texas Health Maintenance Organization Act ([~~Texas~~] Insurance Code[~~,~~] Chapter 843 [~~20A~~]).

(26) [~~(24)~~] Preexisting Condition--A condition for which medical advice was given or treatment was recommended by, or received from, a physician within six months before the effective date of coverage.

(27) [~~(25)~~] Qualified actuary--An actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

(28) [~~(26)~~] Qualified long-term care insurance contract--A long-term care insurance contract meeting the requirements as contained in Internal Revenue Code of 1986, §7702B(b).

(29) [~~(27)~~] Qualified long-term care services--As the term is defined in Internal Revenue Code of 1986, §7702B(c).

(30) [~~(28)~~] Similar policy forms--All of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Those certificates issued or delivered pursuant to one or more employers or labor union organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations, are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications.

(31) [~~(29)~~] Toileting--Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(32) [~~(30)~~] Transferring--Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on July 7, 2008.

TRD-200803489
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: August 17, 2008
For further information, please call: (512) 463-6327

♦ ♦ ♦

DIVISION 2. NON-PARTNERSHIP AND PARTNERSHIP LONG-TERM CARE INSURANCE

28 TAC §§3.3821, 3.3826, 3.3829, 3.3830, 3.3833, 3.3834, 3.3837 - 3.3839, 3.3842, 3.3844, 3.3846, 3.3848, 3.3849

STATUTORY AUTHORITY. The amendments and new sections are proposed pursuant to the Insurance Code §§1651.004, 1651.101 - 1651.107, and §36.001 and §1917(b) of the Social Security Act (SSA) as amended by §6021 of the Deficit Reduction Act of 2005 (DRA) (pertaining to Expansion of State Long-Term Care Partnership Program) (42 U.S.C. §1396p(b)). Section 1651.004 provides that the Department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651 concerning long-term care benefit plans. SB 22 enacted by the 80th Legislature, Regular Session, effective March 1, 2008, amended Chapter 1651 to add new Subchapter C concerning the Partnership for Long-Term Care Program. Section 1651.101 specifies the definitions that are specific to the Texas partnership program. Section 1651.102 specifies the applicability of Subchapters A (General Provisions) and B (Benefit Plan Standards), which were in effect prior to the enactment of SB 22, to the partnership policies issued in accordance with new Subchapter C. Section 1651.103 requires that the Department assist the Health and Human Services Commission as necessary for the Commission to perform its statutorily specified partnership program duties and functions, as provided in Chapter 32 Subchapter C. of the Human Resources Code. Section 1651.104 requires the Department to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that qualifies as an approved plan under the partnership program and further requires that the standards be consistent with the provisions of the federal DRA. Section 1651.105 requires that each individual who sells a partnership policy must complete training and demonstrate an understanding of how partnership policies relate to other public and private coverage of long-term care and requires each insurer that offers partnership policies to certify to the Commissioner that its agents who sell partnership policies comply with the required training requirements. Section 1651.106 provides that, if the partnership program is discontinued, an individual who has purchased a partnership policy remains eligible to receive the benefits under the partnership policy. Section 1651.107 authorizes the Commissioner to adopt rules as necessary to implement Subchapter C. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The federal enabling legislation regulating qualified partnerships was enacted in the DRA of 2005; it was signed into law on February 8, 2006. Section 6021(a)(1)(A) of the DRA, expands State Long-Term Care Partnership Programs, which encourage individuals to purchase long-term care insurance. State partnership programs are intended to promote consumers' purchase of long-term care insurance from private insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased partnership coverage. The DRA amends §1917(b)(1)(C) of the Social Security Act by adding new clause (iii) to permit states to exempt long-term care benefits from estate recovery, if the state has a state plan amendment filed with and approved by the Department of Health and Human Services Center for Medicaid and Medicare Services that provides for a qualified state long-term care insurance partnership. Additionally, §6021(a)(1)(A) of the DRA enacts several new provisions codified at §1917(b)(1)(C) of the Social Security Act that specify the requirements for partnership policies, including: (i) §1917(b)(1)(C)(iii)(II) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(II)) specifies that the policy must be a qualified long-term care insurance contract as defined in §7702B(b) of the Internal Revenue Code, (ii) §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)) specifies that the policy must meet the consumer protection requirements in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)) which include meeting the requirements of specific portions of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulations and Model Act, (iii) §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the

policy must be issued not earlier than the effective date of the Qualified Partnership, (iv) §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) specifies that the policy must include inflation protection in accordance with the DRA, and (v) §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must cover an insured who is a resident of the state when the coverage first became effective.

CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal: Insurance Code §1651.004 and §1651.104

§3.3821. Limits on Group Long-Term [~~term~~] Care Insurance.
No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in the Insurance Code §1251.056 and §1131.064[~~, Article 3.51-6, §1(a)(6) and Article 3.50 §1(6)~~], unless the Texas Department of Insurance has made a determination that the group long-term care insurance requirements adopted by the State of Texas have been met, and the certificate for group long-term insurance coverage has been properly filed and approved by the department.

§3.3826. Limitations and Exclusions.

(a) No policy or certificate may be delivered or issued for delivery in this state as a long-term care insurance policy or certificate if such policy or certificate limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

(1) - (3) (No change.)

(4) illness, treatment, or medical condition arising out of any of the following:

(A) - (D) (No change.)

(E) aviation activity as a nonfare-paying passenger; [~~or~~]

(5) treatment provided in a governmental facility (unless otherwise required by law); benefits provided under Medicare or other governmental program (except Medicaid); any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance; or [~~.~~]

(6) expenses for services or items available or paid under another long-term care insurance or health insurance policy.

(b) For purposes of this subsection, "state of policy issue" means the state in which the individual policy or certificate was originally issued. No long-term care insurer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions:

(1) when the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or

(2) when the state other than the state of policy issue licenses, certifies or registers the provider under another name.

(c) [~~(b)~~] Provisions of this section are not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

§3.3829. Required Disclosures.

(a) Required Disclosure of Policy Provisions.

(1) - (5) (No change.)

(6) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in the Insurance Code Chapter 1651[~~, Article 3.70-12,~~] or §3.3824 of this subchapter [~~title~~] (relating to Preexisting Conditions Provisions) shall set forth a description of such limitations or conditions in a separate paragraph of the policy or [~~and~~] certificate and shall label each paragraph "Limitations or Conditions on Eligibility for Benefits."

(7) - (12) (No change.)

(b) Required Disclosure [~~disclosure~~] of Rating Practices [~~rating practices~~].

(1) Other than non-cancellable policies or certificates, the required disclosures of rating practices[~~, as~~] set forth in paragraph (2) of this subsection[~~,~~] shall apply to any long-term care policy or certificate delivered or issued for delivery in this state on or after July 1, 2002, except for certificates issued under a group long-term care policy delivered or issued for delivery in this state and issued to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations that was in effect on January 1, 2002, in which case this subsection shall apply on the policy anniversary following January 1, 2003.

(2) Insurers shall provide the following information [~~in the same order~~] as set forth in this paragraph and Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) to the applicant at the time of application or enrollment or, if the method of application does not allow for delivery at that time, the information shall be provided at the time of delivery of the policy or certificate:

(A) (No change.)

(B) an explanation of potential future premium rate revisions, including an explanation of contingent nonforfeiture benefit upon lapse, and the policyholder's or certificate holder's option in the event of a premium rate revision;

(C) (No change.)

(D) a general explanation for applying premium rate or rate schedule adjustments that shall include:

(i) (No change.)

(ii) the right to a revised premium rate or rate schedule as provided in subparagraph (C) of this paragraph [~~subsection~~] if the premium rate or rate schedule is changed;

(E) Information regarding each premium rate increase on this individual or group policy form or similar individual or group policy forms over the past 10 years for this state or any other state that, at a minimum, identifies:

(i) the individual or group policy forms for which premium rates have been increased;

(ii) - (iii) (No change.)

(3) - (7) (No change.)

(8) An insurer shall use the text for Form Number LHL560(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(H) to comply with the requirements in subsection (b)(2)(A) and (E) of this section and Form Number LHL561(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(I) to comply with the requirements in subsection (b)(2)(B), (C), and (D) of this section. The following requirements and procedures apply to Form Number LHL560(LTC) and Form Number LHL561(LTC): [~~may use such form as the department prescribes to comply with the requirements of this section.~~]

(A) The text in each form must be in at least 12-point type and must follow the order of the information presented in the form.

(B) The text and order of presentation of information in each form are mandated; the format for the forms is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) if the insurer files the forms for review and approval by the commissioner as provided in subparagraphs (C) and (F) of this paragraph.

(C) Any form filed pursuant to subparagraph (B) of this paragraph must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(D) An insurer may add a company name and identifying form number to Form Number LHL560(LTC) and Form Number LHL561(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) without obtaining commissioner approval.

(E) The *Instructions to Company* that are included in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) are to aid the insurer in drafting the forms and should not be included in the text of the forms used by the insurer.

(F) The forms filed pursuant to subparagraph (B) of this paragraph should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(G) Persons may obtain the required form by making a request to the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or by accessing the department's [~~department~~] website at www.tdi.state.tx.us. [~~Insurers who elect not to use the prescribed form shall file the disclosure form with the Life/Health Division of the department for review 60 days prior to use.~~]

(H) A representation of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet is as follows:
Figure: 28 TAC §3.3829(b)(8)(H)

(I) A representation of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form is as follows:
Figure: 28 TAC §3.3829(b)(8)(I)

(9) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, as applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by paragraph (2)(B), (C), and (D) of this subsection and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) [~~in the same order as set forth in paragraph (2)~~] when the rate increase is implemented. The notice shall comply with the requirements specified in Figure: 28 TAC §3.3829(b)(8)(I).

§3.3830. Requirements for Application Forms and Replacement Coverage.

(a) - (g) (No change.)

(h) Life Insurance policies with a long-term care rider that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of the Insurance Code Chapter 1114 (relating to Replacement of Certain Life Insurance Policies and Annuities), Subchapter NN of this chapter (relating to Consumer Notices for Life Insurance Policy and Annuity Contract Replacements), and any additional rules adopted by the department pursuant to the Insurance Code Chapter 1114. If a life insurance policy with a long-term care rider that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

§3.3833. Group Certificates; Outline of Coverage Required.

An outline of coverage is required on any group certificate issued for group long-term care insurance issued to a group as defined in the Insurance Code Chapter 1251 Subchapter B, but subject to the exemptions in the Insurance Code §1651.002[~~, Article 3.51-6, §1(a)~~]. Such outline of coverage shall be in a format identical to that which is required for [~~of~~] individual long-term care insurance policies in §3.3832 of this subchapter [~~title~~] (relating to Outline of Coverage), and shall be delivered to prospective enrollees no later than the time that application for group benefits is made.

§3.3834. Organization of Policy Format for Readability.

(a) - (g) (No change.)

(h) Type size and style must [~~shall~~] be legible[~~,~~] and must [~~shall~~] comply with the requirements set forth in the Insurance Code §1201.054[~~, Article 3.70-2(A)(4)~~].

(i) - (k) (No change.)

§3.3837. Reporting Requirements.

(a) Policy or Certificate Replacements and Lapses. The purpose of this subsection is to specify requirements for insurers issuing long-term care insurance benefits in this state to report to the commissioner information on a statewide basis regarding long-term care insurance policy or certificate replacements and lapses.

(1) Agent records

(A) Each [~~Every~~] insurer shall maintain records, for each agent, of that agent's number and dollar amount of replacement sales as a percentage of the agent's total number and amount of annual sales attributable to long-term care products, as well as the number and dollar amount of lapses of long-term care insurance policies sold by the agent and expressed as a percentage of the agent's total annual sales attributable to long-term care products.

(B) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

(2) [~~(1)~~] Reporting of 10 percent of agents. Each insurer shall report by June 30 of every year the information indicated in the parts of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form on the listing of the 10 percent

of agents data as specified in Figure: 28 TAC §3.3837(a)(2) for the 10 percent [~~10%~~] of its agents with the greatest percentages of policy or certificate lapses and replacements during the preceding calendar year. Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website [~~as measured by this subsection; provided, however, that any agent with 20 or fewer sales of long-term care policies for any reporting period shall not be included in such report, even if such agent's replacement-and-lapse percentage rates would otherwise result in inclusion in such report~~].
Figure: 28 TAC §3.3837(a)(2)

[~~(2) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.~~]

(3) Reporting number of lapsed long-term care policies. Each [~~Every~~] insurer shall report by June 30 of every year the number of lapsed long-term care policies as a percentage of its total annual sales of such policies and as a percentage of its total number of long-term care policies in force during [~~as of the end of~~] the preceding calendar year as indicated in the Company Totals part of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form as specified in Figure: 28 TAC §3.3837(a)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

(4) Reporting number of replacement long-term care policies. Each [~~Every~~] insurer shall report by June 30 of every year the number of replacement long-term care policies sold as a percentage of its total annual sales of such products, and as a percentage of its total number of such policies in force during [~~as of~~] the preceding calendar year as indicated in the Company Totals part of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form as specified in Figure: 28 TAC §3.3837(a)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

[~~(5) Every insurer by June 30 of each year shall file the annual rate filing required by Insurance Code Article 3.70-12, §4(b).~~]

(b) Rescissions. Each [~~Every~~] insurer issuing long-term care insurance benefits in this state shall maintain a record of all policy, contract, or certificate rescissions relating to such long-term care insurance benefits, both for coverage in this state and nationwide, except for those which the insured voluntarily effectuated, and shall report this data for the preceding calendar year to the commissioner by June 30[~~30th~~] of every year as indicated on Form Number LHL563(LTC) Rescission Reporting Form for Long-Term Care Policies as specified in Figure: 28 TAC §3.3837(b). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website [~~this information utilizing Form LTC RESCIND as referenced in §3.3848 of this title (relating to Adoption by Reference of Department Form Utilized in Reporting)~~].
Figure: 28 TAC §3.3837(b)

(c) Claims Denied by Class of Business.

(1) Definitions. For purposes of this subsection, the following terms shall have the following meanings.

(A) Claim--A request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(B) Denied--The insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

(2) Report of Claims Denied. Each

[~~(c)~~] [~~Every~~] insurer issuing long-term care insurance benefits in this state shall maintain a record by class of business of the number of long-term care claims for long-term care services denied during the preceding calendar year in this state. The insurer shall report the number of claims denied for each class of business [~~this information~~] expressed as a percentage of claims denied [~~(other than claims denied for failure to meet the waiting period or because of any applicable preexisting conditions or because the service for which the claim was submitted is not the type of service covered by a long-term care policy)~~] to the commissioner by June 30 [~~30th~~] of every year as indicated on Form Number LHL564(LTC) Long-Term Care Insurance Claim Denials Reporting Form as specified in Figure: 28 TAC §3.3837(c)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.
Figure: 28 TAC §3.3837(c)(2)

(d) Long-Term Care Partnership Program. Each insurer that markets partnership policies in this state shall report to the department by June 30 of each year the information required in §32.107 of the Human Resources Code, specifying the number of approved partnership plans sold in this state during the preceding calendar year and the average age of individuals purchasing approved partnership plans during the preceding calendar year in this state. The information required in this subsection shall be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in Figure: 28 TAC §3.3837(e). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website. [~~For purposes of this section, reporting requirements relate only to long-term care insurance and coverage that are delivered or issued for delivery in this state.~~]

(e) Data Report for Non-Partnership Plans. Each insurer that markets long-term care insurance in this state shall report to the department by June 30 of each year the number of non-partnership plans sold in this state during the preceding calendar year and the average age of individuals purchasing such non-partnership plans. The information required in this subsection shall be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in Figure: 28 TAC §3.3837(e). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.
Figure: 28 TAC §3.3837(e)

(f) Suitability Data. Each insurer issuing long-term care benefits in this state shall report suitability data for this state for the preceding calendar year to the commissioner by June 30 of each year as indicated on Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form as specified in Figure: 28 TAC §3.3837(f). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.
Figure: 28 TAC §3.3837(f)

(g) Demonstration of compliance with applicable loss ratio standards. Each insurer shall file by June 30 of each year the annual rate filing required by the Insurance Code §1651.053(c) to demonstrate compliance with the applicable loss ratios of this state and any other filing requirement adopted by the commissioner relating to loss ratios. The filing must be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701. Such demonstration shall be in addition to any demonstration required

under §3.3831(c)(2)(B) - (D) of this subchapter (relating to Standards and Rates) and shall include the following information by calendar duration, separately by form number:

(1) calendar duration;

(2) first year issued;

(3) actual earned premium by duration;

(4) actual incurred claims;

(5) actual calendar duration loss ratio;

(6) anticipated calendar duration loss ratio; and

(7) number of insured lives.

§3.3838. Filing Requirements for Advertising.

A long-term care insurance policy shall not be deemed to meet the standards and requirements set forth in this subchapter unless the filing company has complied with the requirements of the following paragraphs.

(1) Each [~~Every~~] insurer or other entity providing long-term care insurance or benefits in this state shall provide to the commissioner for review a copy of any long-term care insurance advertisement, as defined in §21.102 of this title (relating to Scope of insurance advertising, certain trade practices, and solicitation), other than an institutional advertisement as defined in §21.102 of this title that only references long-term care insurance as a line of coverage offered, but which does not otherwise describe long-term care insurance or benefits [~~used to promote a policy which is approved under the provisions of this subchapter~~]. The copy of the advertisement shall be submitted to the commissioner no later than 60 days prior to its first use. At the expiration of the 60-day period provided by this paragraph, any advertisement filed with the commissioner shall be deemed acceptable, unless before the end of that 60-day period the commissioner has notified the entity of its nonacceptance.

(2) - (3) (No change.)

§3.3839. Standards for Marketing.

(a) Each [~~Every~~] insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its agents, shall establish and implement marketing procedures to assure that:

(1) - (5) (No change.)

(6) the terms non-cancellable and level premium are used only to describe a policy or certificate that conforms to §3.3810 of this subchapter (relating to Policy or Certificate Standards for Noncancellability); [~~and~~]

(7) auditable procedures are established [~~in place~~] to verify compliance with this subsection;[~~.~~]

(8) at time of solicitation, the insurer provides written notice to the prospective policyholder and certificate holder that a senior insurance counseling program is available from the department and the name, address and telephone number of the program;

(9) at the time of application, an explanation is provided to the applicant of the contingent nonforfeiture benefit upon lapse provided for in §3.3844(g)(1) of this subchapter (relating to Nonforfeiture and Contingent Nonforfeiture Benefits) and, if applicable, an explanation of the additional contingent benefit upon lapse provided for policies or certificates with fixed or limited premium payment periods as specified in §3.3844(g)(2) of this subchapter;

(10) at the time of application, copies of the disclosure forms (Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) are provided to the applicant; and

(11) [~~(b)~~] [~~Every insurer or other entity marketing long-term care insurance coverage in this state, directly or through its agents, shall ensure that~~] the notice required [~~provided~~] in subparagraph (A) or (B) [~~paragraph (1) or (2)~~] of this paragraph [~~subsection~~], as appropriate, is prominently displayed by type, stamp, or other appropriate means on the first page of both the policy (or certificate) and the outline of coverage.

(A) [~~(1)~~] For any policy or certificate which contains inflation protection provisions, the notice shall read as follows: "Notice to buyer: This policy (or certificate) may not cover all of the costs associated with long-term care incurred by the policyholder (or certificate holder) during the period of coverage. The policyholder (or certificate holder) is advised to review carefully all policy limitations."

(B) [~~(2)~~] For any policy or certificate which does not contain inflation protection provisions, the notice shall read as follows: "Notice to buyer: This policy (or certificate) may not cover all of the costs associated with long-term care incurred by the policyholder (or certificate holder) during the period of coverage. The policyholder (or certificate holder) is advised to review carefully all policy limitations. In addition, the policyholder (or certificate holder) is advised that based on current health care cost trends, the benefits provided by this policy (or certificate) may be significantly diminished in terms of real value to the policyholder (or certificate holder), depending on the amount of time which elapses between the date of purchase and the date upon which the policyholder (or certificate holder) first becomes eligible for those benefits."

(b) [~~(c)~~] The marketing of a long-term care insurance policy or certificate which includes benefits provisions under §3.3818(b) of this subchapter [~~title~~] (relating to Standards for Eligibility for Benefits) shall disclose within a common location and in equal prominence a description of all benefit levels payable for coverage described in §3.3818(b).

(c) [~~(d)~~] In addition to the practices prohibited in the Insurance Code Chapter 541[~~, Article 21.21~~], the following acts and practices are unfair methods of competition or unfair or deceptive acts or practices in the marketing of long-term care policies or certificates in this state and are prohibited under §541.003 of the Insurance Code.

(1) Twisting--Knowingly making any misleading representation or incomplete or fraudulent comparisons of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics--Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising--Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) Misrepresentation--Selling, marketing, offering, or advertising any insurance policy, certificate, or rider to such policy or certificate, which substantially meets the definition of long-term care

insurance found in the Insurance Code §1651.003 [~~Article 3.70-12, §2~~], but which provides benefits for a period of fewer than 12 months.

§3.3842. Appropriateness of Recommended Purchase.

(a) In recommending the purchase or replacement of any long-term care insurance policy or certificate, the company and the agent shall make reasonable efforts to determine the appropriateness of the recommended purchase or replacement.

(b) Each insurer, health care service plan, or other entity marketing long-term care insurance (issuer) shall:

(1) develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) train its agents in the use of its suitability standards; and

(3) maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(c) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following factors into consideration:

(1) the applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(3) the values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(d) The issuer and, where an agent is involved, the agent, shall make reasonable efforts to obtain the information set forth in subsection (c) of this section. The efforts shall include presentation to the applicant, at or prior to application, the Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H). The issuer may request the applicant to provide additional information to comply with the issuer's suitability standards. The following requirements apply if the issuer requests such additional information on the personal worksheet:

(1) A copy of the issuer's Long-Term Care Insurance Personal Worksheet Form Number LHL560(LTC) that includes the additional information that is requested to comply with the issuer's suitability standards must be filed with the department for approval prior to use.

(2) Any form filed pursuant to paragraph (1) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(3) The filing should be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(e) The issuer must receive the completed personal worksheet from the applicant prior to the issuer's consideration of the applicant for coverage, except the completed personal worksheet does not need to be received by the issuer prior to the issuer's consideration of an applicant for coverage for employer group long-term care insurance for employees and their spouses.

(f) The sale or dissemination outside of the company or agency by the issuer or agent of information obtained through the completion of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet, including any additional information provided to comply with the issuer's suitability standards, is prohibited.

(g) The issuer shall use the suitability standards that it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(h) Agents must use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

(i) At the same time that the personal worksheet is provided to the applicant, Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance, containing the text specified in Figure: 28 TAC §3.3842(i)(7) must also be provided to the applicant. The following requirements and procedures apply to this form:

(1) The text must be in at least 12-point type and must follow the order of the information presented in Figure: 28 TAC §3.3842(i)(7).

(2) The text as specified in Figure: 28 TAC §3.3842(i)(7) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3842(i)(7) if the insurer files the form for review and approval by the commissioner.

(3) The form must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) An insurer may add a company name and identifying form number to Form Number LHL567(LTC) as specified in Figure: 28 TAC §3.3842(i)(7) without obtaining commissioner approval.

(5) The Instructions to Company that are included in Figure: 28 TAC §3.3842(i)(7) are to aid the insurer in drafting the form and should not be included in the text of the form used by the insurer.

(6) If filing the form for review and approval as provided under paragraphs (2) and (3) of this subsection, the insurer must file the form with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(7) A representation of Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance is as follows:
Figure: 28 TAC §3.3842(i)(7)

(j) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide all of the requested information, the issuer may reject the application or the issuer must send the applicant a letter in accordance with Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. This method, at the option of the issuer, may include phone call, fax, U.S. mail, email or any combination of these methods. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. If the issuer elects to send the applicant a Suitability Letter to comply with the requirements of this subsection, the following specifies the Suitability Letter requirements and procedures apply:
Figure: 28 TAC §3.3842(j)

(1) The issuer's Suitability Letter must use the text in Form Number LHL568(LTC) as specified in Figure: 28 TAC §3.3842(j).

(2) The text must be in at least 12-point type and must follow the order of the information presented in Figure: 28 TAC §3.3842(j).

(3) The *Instructions to Company* that are included in Figure: 28 TAC §3.3842(j) are to aid the issuer in drafting the form and should not be included in the text of the letter sent to the applicant.

(4) The form number should not be included on the letter sent to the applicant.

§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits.

(a) - (b) (No change.)

(c) Nonforfeiture Benefit Options. Insurers shall offer at least one of the following nonforfeiture options:

(1) - (2) (No change.)

(3) shortened [~~shorten~~] benefit period; or

(4) (No change.)

(d) (No change.)

(e) Benefits Continued as Nonforfeiture Benefits. This subsection applies to contingent nonforfeiture benefits upon lapse in accordance with subsection (g)(1) of this section but does not apply to contingent nonforfeiture benefits upon lapse in accordance with subsection (g)(2) of this section: [~~Additional Requirements for Shortened Benefit Period. An insurer offering a shorten benefit period shall comply with the following:~~]

(1) - (2) (No change.)

(3) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50 and at least three percent per year beyond age 50.

(f) (No change.)

(g) Contingent Nonforfeiture Benefits.

(1) (No change.)

(2) A contingent nonforfeiture benefit on lapse shall also be triggered for policies or certificates with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Figure: 28 TAC §3.3844(g)(2) based on the insured's issue age, the policy or certificate lapses after notice of the rate increase is issued and within 120 days before or after notice of the due date of the premium so increased, and the ratio in paragraph (4)(B) of this subsection is 40 percent or more. Unless otherwise required, policyholders must be notified at least 45 days prior to the due date of the premium reflecting the rate increase. The provision of this paragraph shall be in addition to the contingent nonforfeiture benefit provided by subsection (g)(1) of this section and where both are triggered, the benefit provided shall be at the option of the insured.
Figure: 28 TAC §3.3844(g)(2)

(3) [~~(2)~~] On or after the effective date of a substantial premium increase as set forth in paragraph (1) of this subsection, the insurer shall:

(A) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(B) offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (e) of this section. This option may be elected at any time during the 120-day period referenced in paragraph (1) of this subsection; and

(C) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (1) of this subsection shall be deemed to be the election of the offer to convert in subparagraph (B) of this paragraph.

(4) On or before the effective date of a substantial premium increase as defined in paragraph (2) of this subsection, the insurer shall:

(A) offer to reduce policy or certificate benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(B) offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in paragraph (2) of this subsection; and

(C) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (2) of this subsection shall be deemed to be the election of the offer to convert in subparagraph (B) of this paragraph if the ratio is 40 percent or more.

§3.3846. Incontestability Period.

(a) (No change.)

(b) After a policy or certificate has been in force for two years it is not contestable except for the grounds stated in the Insurance Code §1251.103 [~~Article 3.51-6, §1(d)(2)(ii)~~] for a group policy and the Insurance Code §1201.208 [~~Article 3.70-3(A)(2)~~] for an individual policy.

(c) (No change.)

§3.3848. Requirements for Limited Premium Payment Options in Long-Term Care Policies, Certificates, and Riders.

(a) Definition and Applicability. Long-term care policies, certificates, and riders with limited premium payment options limit premium payments to a single payment or to a stated number of years not to exceed 10 years. Limited premium payment policies, certificates, and riders must comply with this subchapter, Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings), and the additional requirements specified in subsection (b) of this section. Any policy, certificate or rider that contains a paid-up option at a specified age and becomes paid up in 10 years or less is subject to this section.

(b) Requirements.

(1) Notice. The face page of a long-term policy or certificate with a limited premium payment option must accurately reflect a plan with a limited premium payment option.

(2) Minimum Standards. The provisions in long-term care policies, certificates, and riders with limited premium payment options must be at least as favorable as the requirements and provisions specified in this section.

(3) Single-Premium Payment Option. A single-premium payment option policy, certificate, or rider must be noncancellable as provided in §3.3810(a) of this subchapter (relating to Policy or Certificate Standards for Noncancellability). The renewability provision on

the face page of the policy or certificate must conform with the following: "NONCANCELLATION PROVISION: This policy provides that premiums are paid by a single premium after which no additional premiums are due and your policy is fully paid-up and noncancellable. We cannot cancel your policy and we cannot make any changes unless requested by you, subject to the maximum benefits under the policy."

(4) One-to-Four Year Premium Payment Options. A long-term care policy, certificate, or rider with a one-to-four year premium payment option must be noncancellable as provided in §3.3810(a) of this subchapter. The renewability provision on the face page of a policy or certificate must conform with the following: "NONCANCELLATION PROVISION: This policy provides that your premiums may be paid over a period of [n] (n may equal 1, 2, 3, or 4) years, after which no additional premiums will be due and your policy is fully paid up and noncancellable. We cannot cancel your policy and we cannot make any changes unless requested by you, subject to the maximum benefits under the policy."

(5) Five-to-Ten Year Premium Payment Options. A long-term care policy, certificate or rider with a five-to-ten year premium payment option must be guaranteed renewable as provided in §3.3807(a) of this subchapter (pertaining to Policy or Certificate Standards for Guaranteed Renewability) and must comply with the following requirements:

(A) The renewability provision on the face page of a long-term care policy or certificate must conform to the following: "This policy provides that your premiums be paid over a period of [n] (n may equal 5, 6, 7, 8, 9 or 10) years, after which no additional premiums will be due and your policy is fully paid-up and noncancellable. We cannot cancel your policy and we cannot make any changes unless requested by you, subject to the maximum benefits under the policy."

(B) A provision must be included in the policy, certificate or rider that provides for a return of premium upon cancellation, as described in Figure: 28 TAC §3.3848(b)(5)(C)(ii).

(C) Each long-term care policy, certificate or rider must be accompanied by the disclosure specified in clause (i) of this subparagraph and the Return of Premium chart specified in Figure: 28 TAC §3.3848(b)(5)(C)(ii).

(i) Disclosure. The return of premium provision must conform with the following: "RETURN OF PREMIUM: Upon cancellation of this policy by you during the premium-paying period, we will return a portion of the total premiums paid less any benefits paid under the policy. The portion of the total premium paid will be determined in accordance with the accompanying chart, labeled Return of Premium Schedule."

(ii) Return of Premium Schedule. The return of Premium Schedule chart, which specifies the percentage of premium that the insurer is required to return to the insured expressed as a function of the premium payment option (5, 6, 7, 8, 9, and 10 year premium payment options) and of the number of completed years prior to the policy, certificate or rider being canceled, must comply with the following requirements:

Figure: 28 TAC §3.3848(b)(5)(C)(ii)

(I) The chart must be in not less than 12-point bold type.

(II) The chart must conform to the representation in Figure: 28 TAC §3.3848(b)(5)(C)(ii), and must be labeled "Return of Premium Schedule".

(iii) Under no circumstances shall the application of §3.3848(b)(5)(C)(ii) result in an amount that exceeds the aggregate premiums paid under the contract, when combined with any other provision of this chapter.

(D) Using the Return of Premium Chart specified in Figure: 28 TAC §3.3848(b)(5)(C)(ii), the return of premium amount must be at least as great as the sum of clauses (i) plus (ii) minus (iii) of this subparagraph:

(i) [(I) - (II)] X (III), where (I), (II) and (III) are as follows:

(I) the cumulative premium paid under the limited premium payment option specified in the policy, certificate, or rider;

(II) the cumulative premium that would have been paid under a lifetime premium payment option;

(III) the percentage specified in Figure: 28 TAC §3.3848(b)(5)(C)(ii), corresponding to the number of completed policy years and limited premium payment period specified in the policy, certificate, or rider;

(ii) the pro-rata unearned premium based on the premium paid for the year of cancellation;

(iii) any benefits paid under the policy.

(E) An example of the calculation of the return of premium required under this section is as follows:

(i) Given the facts provided in subclauses (I), (II), (III), and (IV) of this clause as follows:

(I) policy, certificate, or rider issue date: January 1, 2006;

(II) date of cancellation: April 1, 2008;

(III) 10-pay annual premium: $10,000;

(IV) annual lifetime premium: $1,000;

(ii) Portion of return of premium calculated under subparagraph (D)(i) of this paragraph is equal to .05 X [($10,000 + $10,000) - ($1,000 + $1,000)] = .05 X ($20,000 - $2,000) = .05 X $18,000 = $900;

(iii) Portion of return of premium calculated under subparagraph (D)(ii) of this paragraph is equal to $10,000 X 9/12 = $7,500;

(iv) Total return of premium due is equal to $900 + $7,500 = $8,400 less any benefits paid under the policy.

§3.3849. Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies.

(a) Insurer Requirements.

(1) Any insurer issuing long-term care insurance to an association, as defined in the Insurance Code §1251.052, shall file with the department in accordance with the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) the following:

(A) the long-term care policy and certificate,

(B) a corresponding outline of coverage, and

(C) annual certification of the association's compliance with marketing standards for long-term care policies and certificates in accordance with Form Number LHL573(LTC) Insurer Certification of Association Marketing Compliance specified in §3.3849(e)(1)(F).

(2) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the department the information required in this subsection.

(b) Advertisements. Advertisements for long-term care insurance must be filed with the department in accordance with §3.3838(1) of this subchapter (relating to Filing Requirements for Advertising).

(c) Association Disclosure Requirements.

(1) An association must disclose in any long-term care insurance solicitation to its members:

(A) the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(B) a brief description of the process under which the policies and the insurer issuing the policies were selected.

(2) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(d) Board Approval Requirements. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies and certificates as well as the compensation arrangements made with the insurer.

(e) Insurer Certification Form.

(1) The following requirements and procedures apply to Form Number LHL573(LTC) Insurer Certification of Association Marketing Compliance specified in Figure: 28 TAC §3.3849(e)(1)(F):

(A) The text must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3849(e)(1)(F).

(B) The text of Form Number LHL573(LTC) Insurer Certification of Association Marketing Compliance as specified in Figure: 28 TAC §3.3849(e)(1)(F) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3849(e)(1)(F) if the insurer files the reformatted certification form for review and approval by the commissioner.

(C) Any reformatted certification form that is filed for approval pursuant to paragraph (2) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(D) Any reformatted certification form filed pursuant to paragraph (2) of this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(E) Form Number LHL573(LTC) Insurer Certification of Association Marketing Compliance may be obtained from the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or from the department's website at www.tdi.state.tx.us.

(F) A representation of Form Number LHL573(LTC) Insurer Certification of Association Marketing Compliance is as follows:

Figure: 28 TAC §3.3849(e)(1)(F)

(2) The initial certification shall be submitted to the department between January 1, 2009 and January 31, 2009, for the calendar year 2008, and thereafter shall be submitted annually between January 1 and January 31 for the preceding calendar year.

(3) Form Number LHL573(LTC) is an informational filing pursuant to §3.5(b)(1) of this chapter (relating to Filing Authorities and Categories) and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(4) The annual completed certification form submitted pursuant to paragraphs (2) and (3) of this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on July 7, 2008.

TRD-200803490
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: August 17, 2008
For further information, please call: (512) 463-6327

♦ ♦ ♦

DIVISION 3. NON-PARTNERSHIP LONG-TERM CARE INSURANCE ONLY

28 TAC §3.3860

STATUTORY AUTHORITY. The new section is proposed pursuant to the Insurance Code §§1651.004, 1651.101 - 1651.107, and §36.001 and §1917(b) of the Social Security Act (SSA) as amended by §6021 of the Deficit Reduction Act of 2005 (DRA) (pertaining to Expansion of State Long-Term Care Partnership Program) (42 U.S.C. §1396p(b)). Section 1651.004 provides that the Department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651 concerning long-term care benefit plans. SB 22 enacted by the 80th Legislature, Regular Session, effective March 1, 2008, amended Chapter 1651 to add new Subchapter C concerning the Partnership for Long-Term Care Program. Section 1651.101 specifies the definitions that are specific to the Texas partnership program. Section 1651.102 specifies the applicability of Subchapters A (General Provisions) and B (Benefit Plan Standards), which were in effect prior to the enactment of SB 22, to the partnership policies issued in accordance with new Subchapter C. Section 1651.103 requires that the Department assist the Health and Human Services Commission as necessary for the Commission to perform its statutorily specified partnership program duties and functions, as provided in Chapter 32 Subchapter C. of the Human Resources Code. Section 1651.104 requires the Department to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that qualifies as an approved plan under the partnership program and further requires that the standards be consistent with the provisions of the federal DRA. Section 1651.105 requires that each individual who sells a partnership policy must complete training and demonstrate an understanding of how partnership policies relate to other public and private

coverage of long-term care and requires each insurer that offers partnership policies to certify to the Commissioner that its agents who sell partnership policies comply with the required training requirements. Section 1651.106 provides that, if the partnership program is discontinued, an individual who has purchased a partnership policy remains eligible to receive the benefits under the partnership policy. Section 1651.107 authorizes the Commissioner to adopt rules as necessary to implement Subchapter C. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The federal enabling legislation regulating qualified partnerships was enacted in the DRA of 2005; it was signed into law on February 8, 2006. Section 6021(a)(1)(A) of the DRA, expands State Long-Term Care Partnership Programs, which encourage individuals to purchase long-term care insurance. State partnership programs are intended to promote consumers' purchase of long-term care insurance from private insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased partnership coverage. The DRA amends §1917(b)(1)(C) of the Social Security Act by adding new clause (iii) to permit states to exempt long-term care benefits from estate recovery, if the state has a state plan amendment filed with and approved by the Department of Health and Human Services Center for Medicaid and Medicare Services that provides for a qualified state long-term care insurance partnership. Additionally, §6021(a)(1)(A) of the DRA enacts several new provisions codified at §1917(b)(1)(C) of the Social Security Act that specify the requirements for partnership policies, including: (i) §1917(b)(1)(C)(iii)(II) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(II)) specifies that the policy must be a qualified long-term care insurance contract as defined in §7702B(b) of the Internal Revenue Code, (ii) §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)) specifies that the policy must meet the consumer protection requirements in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)) which include meeting the requirements of specific portions of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulations and Model Act, (iii) §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must be issued not earlier than the effective date of the Qualified Partnership, (iv) §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) specifies that the policy must include inflation protection in accordance with the DRA, and (v) §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must cover an insured who is a resident of the state when the coverage first became effective.

CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal: Insurance Code §1651.004 and §1651.104

§3.3860. Policy Summary Requirements for Non-partnership Life Insurance Policies and Annuity Contracts that Provide Long-Term Care Benefits.

(a) At the time of delivery of a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider, a policy summary shall be delivered. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. The policy summary must comply with all applicable requirements of this section and must include:

(1) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) any exclusions, reductions and limitations on benefits of long-term care;

(4) a statement that any long-term care inflation protection option required by §3.3820 of this subchapter (relating to Requirement to Offer Inflation Protection) and §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) is not available under this policy;

(5) if applicable to the policy type:

(A) a disclosure of the effects of exercising other rights under the policy;

(B) a disclosure of guarantees related to long-term care costs of insurance charges; and

(C) a disclosure of current and projected maximum lifetime benefits.

(b) The provisions of the policy summary required in subsection (a) of this section may be incorporated into a basic illustration that is required to be delivered in accordance with Chapter 21, Subchapter N of this title (relating to Life Insurance Illustrations).

(c) During the entire time that a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(1) any long-term care benefits paid out during the month;

(2) an explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

(3) the amount of long-term care benefits existing or remaining.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on July 7, 2008.

TRD-200803491
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: August 17, 2008
For further information, please call: (512) 463-6327

♦ ♦ ♦

DIVISION 4. PARTNERSHIP LONG-TERM CARE INSURANCE ONLY

28 TAC §§3.3870 - 3.3874

STATUTORY AUTHORITY. The new sections are proposed pursuant to the Insurance Code §§1651.004, 1651.101 - 1651.107, and §36.001 and §1917(b) of the Social Security Act (SSA) as amended by §6021 of the Deficit Reduction Act of 2005 (DRA) (pertaining to Expansion of State Long-Term Care Partnership Program) (42 U.S.C. §1396p(b)). Section 1651.004 provides that the Department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651 concerning long-term care benefit plans. SB 22 enacted by the 80th Legislature, Regular Session, effective March 1, 2008, amended Chapter 1651 to add new Subchapter C concerning the Partnership for Long-Term Care Program. Section 1651.101 specifies the definitions that are specific to the Texas partnership program. Section 1651.102 specifies the applicability of Subchapters A (General Provisions) and B (Benefit Plan Standards), which were in effect prior to the enactment of SB 22, to the partnership policies issued in accordance with new Subchapter C. Section 1651.103 requires that the Department assist the Health and Human Services Commission as necessary for the Commission to perform its statutorily specified partnership program duties and functions, as provided in Chapter 32 Subchapter C. of the Human Resources Code. Section 1651.104 requires the Department to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that qualifies as an approved plan under the partnership program and further requires that the standards be consistent with the provisions of the federal DRA. Section 1651.105 requires that each individual who sells a partnership policy must complete training and demonstrate an understanding of how partnership policies relate to other public and private coverage of long-term care and requires each insurer that offers partnership policies to certify to the Commissioner that its agents who sell partnership policies comply with the required training requirements. Section 1651.106 provides that, if the partnership program is discontinued, an individual who has purchased a partnership policy remains eligible to receive the benefits under the partnership policy. Section 1651.107 authorizes the Commissioner to adopt rules as necessary to implement Subchapter C. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The federal enabling legislation regulating qualified partnerships was enacted in the DRA of 2005; it was signed into law on February 8, 2006. Section 6021(a)(1)(A) of the DRA, expands State Long-Term Care Partnership Programs, which encourage individuals to purchase long-term care insurance. State partnership programs are intended to promote consumers' purchase of long-term care insurance from private insurers by providing consumers access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased partnership coverage. The DRA amends §1917(b)(1)(C) of the Social Security Act by adding new clause (iii) to permit states to exempt long-term care benefits from estate recovery, if the state has a state plan amendment filed with and approved by the Department of Health and Human Services Center for Medicaid and Medicare Services that provides for a qualified state long-term care insurance partnership. Additionally, §6021(a)(1)(A) of the DRA enacts several new provisions codified at §1917(b)(1)(C) of the Social Security Act that specify the requirements for partnership policies, including: (i) §1917(b)(1)(C)(iii)(II) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(II)) specifies that the policy must be a qualified long-term care insurance contract as defined in §7702B(b) of the Internal Revenue Code, (ii) §1917(b)(1)(C)(iii)(III) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(III)) specifies that the policy must meet the consumer protection requirements in §1917(b)(5)(A) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(5)(A)) which include meeting the requirements of specific portions of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulations and Model Act, (iii) §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must be issued not earlier than the effective date of the Qualified Partnership, (iv) §1917(b)(1)(C)(iii)(IV) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) specifies that the policy must include inflation protection in accordance with the DRA, and (v) §1917(b)(1)(C)(iii)(I) of the Social Security Act (SSA) as amended by the Deficit Reduction Act (DRA) (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must cover an insured who is a resident of the state when the coverage first became effective.

CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal: Insurance Code §1651.004 and §1651.104

§3.3870. Exchange Requirements for Long-Term Care Partnership Policies.

(a) Notification and Offer of Exchange. Any insurer that begins to advertise, market, offer, sell, or issue policies that qualify under the Texas Long-Term Care Partnership Program is required to offer on a one-time basis to all policyholders and certificate holders that were issued long-term care coverage by the insurer on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate. The insurer is required to offer the option to exchange in writing by December 31, 2009.

(b) New Coverage. The insurer shall make the new coverage available in one of the following ways:

(1) by adding a rider or endorsement to the existing policy and charging a separate premium for the new rider or endorsement based on the insured's attained age if an additional premium is appropriate; or

(2) by exchanging the existing policy or certificate for a new partnership policy or certificate.

(A) If the new coverage has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing coverage, based on uniform assumptions as determined on the date of issue for a new insured, then the following two requirements apply:

(i) the new policy shall not be underwritten; and

(ii) the rate charged for the new policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy.

(B) If the new coverage has an actuarial value of benefits exceeding the actuarial value of benefits of the existing coverage,

based on uniform assumptions, as determined on the date of issue for a new insured, then the following two requirements apply:

(i) the insurer shall apply its new business, long-term care underwriting guidelines to the increased benefits only; and

(ii) the rate charged for the new policy shall be determined using the method set forth in subparagraph (A)(ii) of this paragraph for the existing benefits, increased by the rate for the increased benefits using the current attained age and risk class of the insured for the increased benefits only.

(c) Exchange Requirements. Any exchange of an existing long-term care policy or certificate for a partnership policy or certificate must comply with the following requirements:

(1) Any offer of exchange shall be made to all policyholders on a nondiscriminatory basis.

(2) An exchange offer shall be deferred to all policyholders who are currently eligible for benefits, within an elimination period on a claim, or who would not be eligible to apply for coverage due to issue age limitations under the new policy, until such time when such condition expires.

(3) All rates for exchanges must meet the requirements specified in §3.3831 of this subchapter (relating to Standards and Rates). In accordance with §3.3831, exchange policies may be underwritten, and the premium may be increased, subject to §3.3810 of this subchapter (relating to Policy or Certificate Standards for Noncancellability).

(4) The new coverage offered shall be on a form that is currently approved for sale in the general market.

(5) In the event of an exchange, the insured shall not lose any rights, benefits or built-up value that have accrued under the original policy with respect to the benefits provided under the original policy, including, but not limited to, rights established because of the lapse of time related to pre-existing condition exclusions, elimination periods, or incontestability clauses.

(d) Exchanges and Not Replacements. Policies issued pursuant to this section shall be considered exchanges and not replacements.

(e) One-time Reporting Requirement. An insurer is required to report exchanges made pursuant to this section on a one-time basis for the 2009 reporting period (to be reported by June 30, 2010) on Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form in accordance with the procedures and requirements specified in §3.3837(a)(4) of this subchapter (relating to Reporting Requirements).

§3.3871. Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies and Certificates.

(a) Standards.

(1) General requirements. In addition to the required filing and approval pursuant to §3.3873 of this subchapter (relating to Filing Requirements for Long-Term Care Partnership Policies), any policy or certificate marketed or represented to qualify as a long-term care partnership policy or certificate must comply with the following requirements:

(A) the insured individual was a resident of Texas when coverage first became effective under the policy. If the policy or certificate is later exchanged for a different long-term care policy or certificate, the individual was a resident of Texas when coverage under the first policy became effective;

(B) the policy is intended to be a qualified long-term care insurance policy under the provisions of §3.3847 of this subchapter (relating to Qualified Long-Term Care Insurance Contracts; Prohibited Representations);

(C) the policy or certificate is issued with and retains inflation coverage that meets the inflation standards specified in §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) based on the insured's then attained age;

(D) the effective date of the partnership policy shall be the date that the partnership policy is issued or the date the application for the partnership policy was signed.

(2) Required disclosure notice.

(A) A policy or certificate represented or marketed as a long-term care partnership policy or certificate shall be accompanied by a disclosure notice that explains the benefits associated with the policy or certificate. The required disclosure notice is set forth in Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(B) The following requirements and procedures apply to Form Number LHL569(LTC):

(i) The text in the notice must be in at least 12-point type and must follow the order of the information presented in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(ii) The text in the notice as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) if the insurer files the form for review and approval by the commissioner.

(iii) Any form filed pursuant to clause (ii) of this subparagraph must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(iv) An insurer may add a company name and identifying form number to Form Number LHL569(LTC) as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) without obtaining commissioner approval.

(v) The *Instructions to Company* that are included in Figure: 28 TAC §3.3871(a)(2)(B)(vii) are to aid the insurer in drafting the form and should not be included in the disclosure notice provided by the insurer.

(vi) Any form filed pursuant to clause (ii) of this subparagraph should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(vii) A representation of Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates is as follows:
Figure: 28 TAC §3.3871(a)(2)(B)(vii)

(viii) Any policyholder that exchanges their policy for a partnership policy must be provided with the required Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(ix) When an insurer is made aware that a policyholder or certificate holder has initiated action that will result in the loss of partnership status, the insurer must provide an explanation of how such action impacts the insured in writing. The insurer must also advise the policyholder or certificate holder on how to retain partnership status if possible.

(x) If a partnership plan subsequently loses partnership status, the insurer must explain to the policyholders or certificate holders in writing the reason for the loss of status.

(3) Commissioner certification. Under §1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. §1396p(b)(5)(B)(iii)), the Commissioner of Insurance, in implementing the Texas Long-Term Care Partnership Insurance Program ("Partnership Program"), may certify that long-term care insurance policies and certificates covered under the Partnership Program meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in §1917(b)(5)(A) of the Social Security Act and principally include certain specified provisions of the NAIC Long-Term Care Model Act and Model Regulations (adopted as of October 2000). In providing this certification, the commissioner may reasonably rely upon the certification by insurers of the policy forms that is made in accordance Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form as specified in Figure: 28 TAC §3.3873(a)(2)(F).

(b) Reporting Requirements. In accordance with §1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act, all issuers of partnership policies or certificates shall provide regular reports to the Secretary of the Department of Health and Human Services (Secretary) in accordance with regulations to be developed by the Secretary. Such information shall include but not be limited to the following:

(1) notification regarding when insurance benefits provided under partnership policies or certificates have been paid and the amount of such benefits paid;

(2) notification regarding when such policies or certificates otherwise terminate; and

(3) any other information the Secretary determines is appropriate.

§3.3872. Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates.

Pursuant to §1917(b)(1)(C)(iii)(IV) of the Social Security Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)), an insurer shall not issue a policy or certificate marketed or represented to qualify as an approved long-term care partnership policy unless the policy or certificate complies with the following inflation protection requirements:

(1) For a person who is less than 61 years of age, as of the date of purchase, the policy or certificate must provide compound annual inflation protection from the date of purchase until the person attains 61 years of age.

(A) At the time of purchase, insurers must offer to each applicant the option to purchase compound annual inflation protection that automatically increases each year on a compounded basis at a rate of not less than 5.0 percent annually throughout the interval of coverage. The inflation protection is required to automatically increase benefits each year on a compounded basis.

(B) If the applicant declines the offer of inflation protection specified in subparagraph (A) of this paragraph, then the insurer must offer and the applicant must purchase and retain compound annual inflation protection until the insured attains age 61 or goes on claim status, whichever comes first. The inflation protection is required to automatically increase benefits each year on a compounded basis at a rate that the insured elects which may be in a range of from one percent to four percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U).

(C) A person who is less than 61 years of age that has purchased a long-term care partnership policy or certificate with the required compound inflation protection specified in this paragraph may upon attaining 61 years of age choose to amend the compound inflation protection provision in the policy or certificate in accordance with the requirements specified in paragraph (2) of this subsection.

(2) For a person who is at least 61 years of age but less than 76 years of age, the policy or certificate must provide an acceptable level of inflation protection until the person attains 76 of years age. Acceptable inflation protection includes the following:

(A) Regardless of the insured's health status, the insurer must offer and the insured must purchase and retain inflation protection until the insured attains age 76 or goes on claim status, whichever comes first.

(B) Acceptable coverage includes automatic annual inflation protection, either simple or compound, paid with either level or stepped premium.

(C) Inflation protection as required by this paragraph may be in a range of from one percent to five percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U).

(D) A person who is less than 76 years of age that has purchased a long-term care partnership policy or certificate with the required inflation protection specified in this paragraph may upon attaining 76 years of age choose to amend the inflation protection provision in the policy or certificate in accordance with the requirements specified in paragraph (3) of this subsection.

(3) For any person who has attained the age of 76, inflation protection may be provided but is not required.

(4) An option to purchase inflation protection at a future time does not constitute compliance with the inflation protection requirements set forth in paragraphs (1) and (2) of this subsection.

§3.3873. Filing Requirements for Long-Term Care Partnership Policies.

(a) Prior Approval Requirements. Each long-term partnership policy or certificate, including any long-term care partnership endorsement, that is to be delivered or issued for delivery in this state must comply with the requirements specified in paragraphs (1) and (2) of this subsection before being delivered or issued in this state.

(1) Each long-term care partnership policy, certificate, or endorsement must be filed with the department and approved by the commissioner in accordance with the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and subsections (b) and (c) of this section, as applicable.

(2) Each long-term care partnership policy, certificate, or endorsement filing must include Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form, as specified in Figure: 28 TAC §3.3873(a)(2)(F). The following requirements and procedures apply to this certification form:

(A) The text in the certification form must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3873(a)(2)(F).

(B) The text in the certification form as specified in Figure: 28 TAC §3.3873(a)(2)(F) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3873(a)(2)(F) if the insurer files the certification form for review and approval by the commissioner.

(C) Any certification form that is filed for approval pursuant to subparagraph (B) of this paragraph must be filed no later than 60 days prior to use in any filing of a policy, certificate or endorsement submitted pursuant to subsection (c) or (d) of this section and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(D) Any certification form filed pursuant to subparagraph (B) of this paragraph should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(E) Form Number LHL570(LTC) may be obtained from the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or from the department's website at www.tdi.state.tx.us.

(F) A representation of Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form is as follows:
Figure: 28 TAC §3.3873(a)(2)(F)

(b) Policies Not Previously Approved. Any policy or certificate, including any endorsement, that has not been previously approved by the commissioner must comply with the requirements specified in paragraphs (1) - (4) of this subsection prior to an insurer offering the policy for sale in Texas as a partnership policy:

(1) The policy, certificate, or endorsement must be filed with the department and approved by the commissioner, and Form Number LHL570(LTC) as specified in subsection (a)(2) of this section must be filed for each policy, certificate, or endorsement form submitted for partnership policy approval.

(2) The policy, certificate, or endorsement form must be in at least 10-point type.

(3) Any filing made pursuant to paragraph (1) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) The filing should be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(c) Previously Approved Policies. Insurers requesting to use a previously approved non-partnership policy form as a long-term care partnership policy must comply with the requirements specified in paragraphs (1) - (6) of this subsection prior to offering the policy for sale in Texas as a partnership policy:

(1) The insurer must file Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form as specified in subsection (a)(2) of this section and must include a copy of any endorsement that is needed to comply with partnership policy requirements.

(2) The policy form number(s) or other identifying information, such as certificate series, must be provided on Form Number LHL570(LTC) as a part of the filing.

(3) The filing must be approved by the commissioner prior to an insurer offering the policy for sale in Texas as a partnership policy.

(4) The policy or certificate does not have to be included in the filing if it has been previously filed and approved by the commissioner.

(5) Any filing made pursuant to this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(6) The filing should be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

§3.3874. Insurer Requirements for Agents that Market Partnership Policies and Certificates.

(a) Insurer Training Verification and Certification Requirements for Agents. The following requirements apply to an insurer that is offering partnership policies or certificates in this state.

(1) The insurer is required to obtain verification that an agent has received the training specified in §19.1022 of this title (relating to Long-Term Care Partnership Certification Course).

(2) Pursuant to the Insurance Code §1651.105(b), the insurer is required to certify to the commissioner that each agent who sells partnership policies or certificates on behalf of the insurer complies with the training requirements of this subsection. The initial certification must be submitted on Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form as specified in Figure: 28 TAC §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form, as specified in Figure: 28 TAC §3.3874(b)(6)(B).

(3) The insurer is required to maintain records of the verification required in paragraph (1) of this subsection for at least four years from the date the verification is received, and the department or its designee may review these records at any time.

(b) Agent Training Certification Form Requirements. The following requirements and procedures apply to Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form as specified in Figure: 28 TAC §3.3874(b)(6)(A) and Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form, as specified in Figure: 28 TAC §3.3874(b)(6)(B):

(1) The text must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3874(b)(6)(A) and in Figure: 28 TAC §3.3874(b)(6)(B).

(2) The text of Form Number LHL571(LTC) as specified in Figure: 28 TAC §3.3874(b)(6)(A) and the text of Form Number LHL572(LTC) as specified in Figure: 28 TAC §3.3874(b)(6)(B) are mandated; the format for the forms is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3874(b)(6)(A) and Figure: 28 TAC §3.3874(b)(6)(B) if the insurer files the reformatted certification form for review and approval by the commissioner.

(3) Any reformatted certification form that is filed for approval pursuant to paragraph (2) of this subsection must be filed no

later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) Any reformatted certification form filed pursuant to paragraph (2) of this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(5) Form Number LHL571(LTC) and Form Number LHL572(LTC) may be obtained from the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or from the department's website at www.tdi.state.tx.us.

(6) Representations of Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form and Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form are specified in subparagraphs (A) and (B) of this paragraph.

(A) A representation of Form Number LHL571(LTC) is as follows:
Figure: 28 TAC §3.3874(b)(6)(A)

(B) A representation of Form Number LHL572(LTC) is as follows:
Figure: 28 TAC §3.3874(b)(6)(B)

(c) Agent Training Certification Filing Requirements. An insurer offering partnership policies or certificates in this state shall submit for the initial certification to the department Form Number LHL571(LTC) Initial Long-Term Care Partnership Agent Training Certification Form containing the text as specified in Figure: 28 TAC §3.3874(b)(6)(A) and shall submit for the subsequent annual certifications to the department Form Number LHL572(LTC) Annual Long-Term Care Partnership Agent Training Certification Form, containing the text as specified in Figure: 28 TAC §3.3874(b)(6)(B), to certify that each individual who sells a long-term care benefit plan for the insurer under the Long-Term Care Partnership Program has completed training and demonstrated evidence of understanding long-term care partnership insurance contracts and how they relate to other public and private coverage of long-term care.

(1) The initial certification Form Number LHL571(LTC) must be submitted to the department between January 1, 2009 and January 31, 2009, and the subsequent annual certification Form Number LHL572(LTC) must be submitted annually between January 1 and January 31 of each year for the preceding calendar year beginning in 2010.

(2) Form Number LHL571(LTC) and Form Number LHL572(LTC) are informational filings pursuant to §3.5(b)(1) of this chapter (relating to Filing Authorities and Categories) and are subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(3) Any certification form submitted pursuant to this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on July 7, 2008.

TRD-200803492

Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: August 17, 2008
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER Y. STANDARDS FOR LONG-TERM CARE INSURANCE COVERAGE UNDER INDIVIDUAL AND GROUP POLICIES

28 TAC §§3.3848 - 3.3850

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Insurance or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Department of Insurance proposes the repeal of §§3.3848 - 3.3850, concerning long-term care insurance. Repeal of these sections is necessary because the need for these rules no longer exists and because of the need to promulgate new long-term care partnership rules and amend current long-term care nonpartnership rules. Simultaneously with this proposed repeal and also published in this issue of the *Texas Register*, the Department is proposing amendments to §§3.3801 - 3.3804, 3.3821, 3.3826, 3.3829, 3.3830, 3.3833, 3.3834, 3.3837 - 3.3839, 3.3842, and 3.3844 - 3.3846, and new §§3.3848, 3.3849, 3.3860, and 3.3870 - 3.3874, to implement SB 22, 80th Legislature, Regular Session, relating to a Partnership for Long-Term Care Program.

The proposed repeal of §3.3848, which relates to the form to be used to report rescissions of long-term care insurance policies, is necessary in order to incorporate all of the Subchapter Y reporting requirements for long-term care insurance into §3.3837. The Department is proposing a new §3.3848 to address requirements for limited premium payment options in long-term care policies and certificates. Repeal of §3.3849, pertaining to 1997 effective dates and grace period, is necessary because it is obsolete. The Department is proposing a new §3.3849 to address certain filing and certification requirements for insurers that issue long-term care policies to associations and marketing standards for associations that market the policies. As previously indicated, the proposed new §3.3848 and §3.3849 are also published in this edition of the *Texas Register*. Repeal of §3.3850, pertaining to Severability, is necessary because these severability provisions are proposed to be incorporated into §3.3803 as part of the promulgation of new long-term care partnership rules in Subchapter Y. The Department is not proposing a new section to replace the repealed §3.3850.

FISCAL NOTE. Ana Smith-Daley, Deputy Commissioner, Life/Health Division, has determined that during the first five years that the proposed repeals are in effect, there will be no fiscal impact on state or local government as a result of enforcing or administering the repeals. There will be no measurable effect on local employment or the local economy as a result of the proposed repeals.

PUBLIC BENEFIT/COST NOTE. Ms. Smith-Daley also has determined that for each year of the first five years that the repeals are in effect, the public benefit anticipated as a result of the repeals will be the elimination of obsolete regulations. There will be no economic cost to any individuals, insurers, or other De-

partment regulated entities, regardless of size, as a result of the proposed repeals.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. In accordance with the Government Code §2006.002(c), the Department has determined that the proposed repeals will not have an adverse economic effect on small businesses or micro businesses. This is because the proposal simply repeals unnecessary and obsolete rules and does not impose any new requirements or costs with which small or micro businesses must comply. Therefore, in accordance with the Government Code §2006.002(c), the Department is not required to prepare a regulatory flexibility analysis.

TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on August 18, 2008 to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Ana Smith-Daley, Deputy Commissioner, Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Any request for a public hearing must be submitted separately to the Office of Chief Clerk before the close of the public comment period. If a hearing is held, written and oral comments presented at the hearing will be considered.

STATUTORY AUTHORITY. The repeal of §§3.3848 - 3.3850 is proposed pursuant to the Insurance Code §36.001, which provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE. No statute is affected by the proposal.

§3.3848. Adoption by Reference of Department Form Utilized in Reporting.

§3.3849. Effective Date; Grace Period and Guarantee Issue Requirement.

§3.3850. Severability.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on July 7, 2008.

TRD-200803488
Gene C. Jarmon
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: August 17, 2008
For further information, please call: (512) 463-6327

♦ ♦ ♦

TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 58. OYSTERS AND SHRIMP

SUBCHAPTER B. STATEWIDE SHRIMP FISHERY PROCLAMATION

31 TAC §58.160

The Texas Parks and Wildlife Department (the department) proposes an amendment to §58.160, concerning Taking or Attempting To Take Shrimp (Shrimping)--General Rules. The proposed amendment would update the reference to federal regulations governing the dimensions and specifications of approved Bycatch Reduction Devices (BRDs) to accommodate recent changes to the federal rules.

Bycatch reduction devices (BRDs) reduce the mortality of nontarget aquatic organisms that occurs during shrimping, especially among juvenile finfish and invertebrate populations. The use of BRDs reduces shrimp-trawl bycatch fishing mortality for recreationally important species such as red snapper, flounder, Atlantic croaker, sand seatrout, and blue crab. The use of BRDs also allows the escapement of other organisms, which enhances the overall viability of the ecosystem and has the potential to increase populations of finfish and invertebrates impacted by trawling.

The state rules requiring shrimp trawls to be equipped with BRDs have been in effect since 2000 and specify that only those BRDs classified by the National Marine Fisheries Service (NMFS) as "approved devices" are lawful for use in waters under state jurisdiction. From time to time NMFS engages in federal rulemaking to designate new or modified BRD types as "approved devices." In a final rule published in the *Federal Register* on February 13, 2008, NMFS added three new BRD types to the list of BRDs approved for use in the federal waters of the Gulf of Mexico (73 FR 8219). The federal rules took effect March 14, 2008.

The proposed amendment to §58.160 would allow the newly approved BRDs to be used in state as well as federal waters. By creating regulatory consistency between state and federal rules, the department intends to enable shrimp vessels that fish in both federal and state waters to continue to do so without having to switch BRDs. The proposed rules also would permit an increased variety of BRDs that could be lawfully used by shrimp vessels, giving fishermen more options in terms of what type of BRD to use. The rule as proposed also would provide for greater economic efficiency in the fishery and would eliminate potential confusion that could result from differential regulations enforced by state and federal authorities.

As required by Parks and Wildlife Code, §77.077, the department finds that the use of BRDs demonstrably reduces bycatch of fish species by shrimp trawls and that the approval of additional types of BRDs neither jeopardizes bycatch species nor causes hardship for shrimpers.

Mr. Robin Riechers, Director of Science and Policy, Coastal Fisheries Division, has determined that for each of the first five years the rule as proposed is in effect, there will be no fiscal implications to state or local government as a result of enforcing or administering the rule.

Mr. Riechers also has determined that for each of the first five years the rule as proposed is in effect, the public benefit anticipated as a result of enforcing or administering the rule as proposed will be a more sustainable shrimp fishery because increasingly efficient BRDs will reduce the impact of that fishery on other bycatch species.

Under the provisions of Government Code, Chapter 2006, a state agency must prepare an economic impact statement and a regulatory flexibility analysis for a rule that may have an adverse economic effect on small businesses and micro-businesses. The department has determined that there will be no direct economic effect on small or micro-businesses or persons required to comply as a result of the proposed rule. The rule would not compel or mandate any action on the part of any entity, including small businesses or microbusinesses. Instead, the rule would create additional flexibility for the shrimp fishing industry by allowing three additional BRD designs to be used. Accordingly, the department has not prepared a regulatory flexibility analysis under Government Code, Chapter 2006.

The department has not drafted a local employment impact statement under the Administrative Procedures Act, §2001.022, as the agency has determined that the rule as proposed will not impact local economies.

The department has determined that Government Code, §2001.0225 (Regulatory Analysis of Major Environmental Rules), does not apply to the proposed rule.

The department has determined that there will not be a taking of private real property, as defined by Government Code, Chapter 2007, as a result of the proposed rule.

Comments are requested on the proposed rule changes from any interested person. Written comments may be submitted to Mr. Paul Hammerschmidt, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744; (512) 389-4650, e-mail: paul.hammerschmidt@tpwd.state.tx.us.

The amendment is proposed under Parks and Wildlife Code, §77.007, which authorizes the commission to regulate the catching, possession, purchase, and sale of shrimp, including the times, places, conditions, and means and manner of catching shrimp.

The proposed amendment affects Parks and Wildlife Code, Chapter 77.

§58.160. Taking or Attempting to Take Shrimp (Shrimping)--General Rules.

(a) - (d) (No change.)

(e) Bycatch Reduction Device (BRD) requirements.

(1) (No change.)

(2) Exemptions from the BRD requirement--A shrimp boat is exempt from the BRD requirements of subsection (e)(1) if it:

(A) (No change.)

(B) Is fishing under the provisions of an [~~a~~] individual bait-shrimp trawl tag as established in §58.165 of [~~,~~] this title [~~chapter~~] (relating to Non-commercial (Recreational) Shrimping).

(C) (No change.)

(3) (No change.)

(4) Approved BRDs:

(A) In outside waters: Any BRD that meets the dimensions and specifications of an approved device as described in 50 Code Federal Regulations (CFR) Part 622 §622.41 on February 13, 2008 [~~Part 622 §622.41(h) on May 15, 2005~~].

(B) In inside waters:

(i) Any BRD (other than an extended funnel devices similar to "Jones/Davis" and "large mesh" devices) that meets the dimensions and specifications of an approved device as described in 50 Code Federal Regulations (CFR) Part 622 §622.41 on February 13, 2008 [~~Part 622 §622.41(h) on May 15, 2005~~]; or

(ii) - (iii) (No change.)

(f) - (g) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on July 1, 2008.

TRD-200803423
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Earliest possible date of adoption: August 17, 2008
For further information, please call: (512) 389-4775

♦ ♦ ♦

ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 8. TEXAS JUDICIAL COUNCIL

CHAPTER 177. JUDICIAL COMMITTEE ON INFORMATION TECHNOLOGY

1 TAC §177.1, §177.2

The Judicial Committee on Information Technology adopts new §177.1 and §177.2, regarding standards for electronic data exchanges. The new rules are adopted with changes to the proposed text as published in the April 4, 2008, issue of the *Texas Register* (33 TexReg 2766). The effective date of the standards is September 1, 2009.

Justification for Rule Action

The public benefit anticipated as a result of the new standards will be the capability for justice agencies and courts to achieve integrated justice; *i.e.,* the use of technology to allow the seamless sharing of information at critical decision points throughout the justice system, thereby improving the quality, accuracy, and timeliness of data by creating intermediary standards-based information exchange models. This goal is vital to enhancing the intrinsic value of the data as it is delivered to the justice, public safety, and homeland security practitioners in the execution of their critical duties.

How the Rule Will Function

The rule functions as standards by which justice agencies and courts will utilize information exchange package documents (IEPDs) developed by the Texas Path to NIEM (National Information Exchange Model) in applicable data exchanges.

Summary of Comments

Two comments, both of which were from justice agencies as defined by the proposed rule, noted that JCIT's statutory authority to develop minimum standards for electronic data interchange and data dictionaries was limited to the judicial system. Both comments suggested that any mandatory language be limited to the courts, and language directed to the justice agencies be permissive or encouraging. JCIT agrees and the rule has been amended accordingly; see §177.2(a) and (b).

Two comments suggested that the new standards should apply only to systems created or initiated after September 1, 2009. JCIT agrees and the rule has been amended accordingly, see §177.2(c).

Two comments suggested clarification that only certain types of data or information exchanges should be covered by the standards, and one was concerned that e-mails and e-filings through Texas Online would be covered. JCIT responds that the rule as drafted only applies to data exchanges among courts and justice agencies, among justice agencies, and among courts. Thus, a filing through Texas Online would not be affected.

Several comments suggested that Texas Integrated Justice Information Systems advisory group (TIJIS) should be referenced as a primary partner in the Path to NIEM project. JCIT regrets the omission in the preamble to the proposed standards, but notes that none of the local and state justice agency collaborators and partners is named in the standards themselves.

One comment expressed concern as to the costs that may be incurred and asked if funding were available to cover any associated costs. JCIT has no such funds, and is not aware of other sources of funds.

Statutory Authority

The new sections are adopted under §77.031(2), Texas Government Code, which authorizes the JCIT to develop minimum standards for electronic data interchange, data dictionaries, and other technological needs of the judicial system. The new rules are expected to support compliance with Chapter 60, Texas Code of Criminal Procedure (Criminal History Record System), §614.017, Texas Health and Safety Code (Exchange of Information [in support of continuity of care for certain offenders]), and the Automated Registry required by OCA Rider 15, General Appropriations Act, 80th Texas Legislature.

No other statutes, articles, or codes are affected by these sections.

§177.1. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Court--Any judge who hears criminal cases or child support cases, and the office of the clerk that supports any such judge.

(2) Information Exchange Package Document (IEPD)--A specification for a data exchange which defines a particular data exchange between participating domains. An IEPD is a complete definition of an Information Exchange Package; it is generally composed of schemas (for data exchange) and documentation (for understanding the business context and usage).

(3) Justice agency--The Texas Department of Criminal Justice (TDCJ), the Department of Public Safety (DPS), the Texas Youth Commission (TYC), the Texas Juvenile Probation Commission (TJPC), the Office of Attorney General Child Support Division (OAG), the Office of Court Administration (OCA), the Department of Family and Protective Services (DFPS), any sheriff or local law enforcement agency that employs a peace officer as defined in art. 2.12, Code of Criminal Procedure, any community supervision and corrections department, any public defender office, any constable, any office of a county or district attorney or criminal district attorney, any private process server, and any agency that receives delinquent

child support notifications from the Office of Attorney General Child Support Division or from a court.

(4) Justice information data exchanges--Exchanges of information pertaining to criminal, juvenile, and family law matters or cases.

(5) NIEM--The National Information Exchange Model, a reference model that is the result of a collaborative effort between the U.S. Department of Justice (DOJ) and the U.S. Department of Homeland Security (DHS) that extends the data exchange standards implemented by the DOJ Global Justice Information Sharing Initiative (the Global Justice XML Data Model). Further information is available at www.niem.gov.

(6) Texas Path to NIEM--The local and state justice agency collaborative work project for implementing NIEM in Texas.

(7) XML--Extensible markup language.

§177.2. NIEM Conformance.

(a) Justice information data exchanges between courts or between a court and OCA shall conform with the IEPDs developed by Texas Path to NIEM.

(b) Justice agencies are encouraged to develop justice information systems whose data exchanges conform with the IEPDs developed by Texas Path to NIEM, and justice information data exchanges between justice agencies or between a court and a justice agency with such capabilities shall conform with those IEPDs.

(c) These standards apply to justice information data exchanges between systems whose development is initiated on or after September 1, 2009.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 1, 2008.

TRD-200803422
Margaret Bennett
General Counsel for Office of Court Administration
Texas Judicial Council
Effective date: July 21, 2008
Proposal publication date: April 4, 2008
For further information, please call: (512) 463-6321

♦ ♦ ♦

TITLE 22. EXAMINING BOARDS

PART 8. TEXAS APPRAISER LICENSING AND CERTIFICATION BOARD

CHAPTER 157. RULES RELATING TO PRACTICE AND PROCEDURE

SUBCHAPTER C. POST HEARING

22 TAC §157.17

The Texas Appraiser Licensing and Certification Board (TALCB) adopts an amendment to §157.17 regarding Final Decisions and Orders with changes to the proposed text as published in the May 23, 2008, issue of the *Texas Register* (33 TexReg 4075).

At adoption, a non-substantive change was made by adding subsection (d) in order to clarify that, consistent with Texas Occupations Code §1103.458(d), a Board member who participates in negotiating a consent order is not disqualified from participating in the adjudication of a contested case that results from the negotiation.

The amendments require Board members to recuse themselves from all participation in any matters about which a real or perceived conflict of interest exists.

The reasoned justification for the amendments is to allow Board members serving on a Peer Investigative Committee pursuant to Texas Occupations Code §1103.453 to participate in the investigation of files assigned to the Committee without violating Texas Government Code §2001.061 regarding *ex parte* communications, thereby enhancing the efficiency of the Board's complaint review processes. While this has been the longstanding Board practice, the public will also be assured of impartial decision-making by the Board because the rules will reflect that members will not participate in decision-making regarding issues about which they have a conflict of interest.

No comments were received regarding the amendments as proposed.

The amendments are adopted under the Texas Occupations Code §1103.154, which authorizes the Texas Appraiser Licensing and Certification Board to adopt rules relating to professional conduct.

§157.17. Final Decisions and Orders.

(a) Board Action. The proposal for decision may be acted upon by the Board after the expiration of 60 days after the date of service of the proposal for decision. Parties shall be notified either personally or by mail of any decision or order. On written request, a copy of the decision or order shall be delivered or mailed to any party and to the respondent's attorney of record.

(b) Imminent Peril. If the Board finds that an imminent peril to the public health, safety, or welfare requires immediate effect on a final decision or order in a contested case, it shall recite the finding in the decision or order as well as the fact that the decision or order is final and effective on the date rendered, in which event the decision or order is final and appealable on the date rendered, and no motion for rehearing is required as a prerequisite for appeal.

(c) Conflict of Interest. A Board member shall recuse himself or herself from all deliberations and votes regarding any matter:

(1) the Board member reviewed as a member of a Peer Investigative Committee;

(2) involving persons or transactions about which the Board member has a conflict of interest;

(3) involving persons or transactions related to the Board member sufficiently closely as to create the appearance of a conflict of interest.

(d) A Board member's participation in the negotiation of a consent order under Texas Occupations Code, §1103.458, does not require recusal under subsection (c) of this section.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 1, 2008.

TRD-200803415

Devon V. Bijansky
Assistant General Counsel
Texas Appraiser Licensing and Certification Board
Effective date: July 21, 2008
Proposal publication date: May 23, 2008
For further information, please call: (512) 465-3900

♦ ♦ ♦

PART 23. TEXAS REAL ESTATE COMMISSION

CHAPTER 537. PROFESSIONAL AGREEMENTS AND STANDARD CONTRACTS

22 TAC §§537.20, 537.28, 537.30 - 537.32, 537.37, 537.39, 537.43 - 537.45

The Texas Real Estate Commission (TREC or Commission) adopts amendments to §537.20 concerning Standard Contract Form TREC No. 9-7; §537.28 concerning Standard Contract Form TREC No. 20-8; §537.30 concerning Standard Contract Form TREC No. 23-8; §537.31 concerning Standard Contract Form TREC No. 24-8; §537.32 concerning Standard Contract Form TREC No. 25-6; §537.37 concerning Standard Contract Form TREC No. 30-7; §537.39 concerning Standard Contract Form TREC No. 32-2; §537.43 concerning Standard Contract Form TREC No. 36-5; §537.44 concerning Standard Contract Form TREC No. 37-3; and §537.45 concerning Standard Contract Form TREC No. 38-2 with changes to the published text and with changes to the forms as proposed in the May 16, 2008, issue of the *Texas Register* (33 TexReg 3883). The amendments adopt by reference six revised contract forms and four addenda for use by Texas real estate licensees.

The change to the text of the rules as adopted from the rules as proposed corrects a typographical error by adding "trec" to the reference to TREC's website address to read www.trec.state.tx.us and to include "property" in reference to a property owner's association in §537.43 and §537.44. The changes to the forms as adopted from those that were originally proposed are detailed below and include the following: The Commission made typographical corrections to the forms adopted by reference and made other changes to the text of the forms in response to comments and further review and recommendation by staff and the Texas Real Estate Broker-Lawyer Committee (BLC). A number of comments did not result in changes to the text of the forms. All comments regarding this adoption, including any not specifically referenced herein, were fully considered by the Commission and the BLC.

The revisions to the forms as adopted do not change the nature or scope so much that they could be deemed different forms. The forms as adopted do not affect individuals other than those contemplated by the forms as proposed. The forms as adopted do not impose more onerous requirements than the proposed versions and do not materially alter the issues raised in the proposed forms. Changes in the forms adopted by reference reflect non-substantive variations from the proposed rules and forms to clarify their intent and improve style and readability.

The reasoned justification for the amendments to the rules and contract forms adopted by reference is to maintain consistency, reduce controversy and misunderstanding, reduce redundancy, and address significant new issues relative to real estate contract forms.

The contract forms are published by TREC and available at the TREC web site (www.trec.state.tx.us) or at the Texas Real Estate Commission, P.O. Box 12188, 1101 Camino La Costa, Austin, TX 78711-2188. Texas real estate licensees are generally required to use forms promulgated by TREC when negotiating contacts for the sale of real property. The revised forms may be used on a voluntary basis upon adoption; licensees will be required to use the forms on a mandatory basis as of September 1, 2008. These forms are drafted by the BLC, an advisory body consisting of six attorneys appointed by the President of the State Bar of Texas, six brokers appointed by TREC, and a public member appointed by the governor.

Drafts of the contract forms were released for comment and displayed on the TREC web site during the notice and comment period after posting in the *Texas Register*. Approximately 12 comments were received during the notice and comment period. Of those comments, 3 were lost due to technical difficulties with agency e-mail services. The San Antonio Board of Realtors, the Houston Association of Realtors, and the MetroTex Association of Realtors commented on the proposed forms.

The comments and Commission responses to those comments are summarized as follows.

Comment: One commenter suggested inserting a "lapse" clause in all the contracts for submitting an offer so that there will be a time limit on the response from the seller to make a decision about the offer. Response: The Commission respectfully disagrees as a clause such as the commenter suggests would be non-binding on the seller if a contract has not been executed between the parties.

Comment: One commenter suggested modifying Paragraph 6 concerning elevation certificates. He suggested adding elevation certificates to the paragraph so that the parties may negotiate whether the seller will provide an elevation certificate or whether the buyer will obtain the certificate at the buyer's or seller's cost. Another commenter suggested modifying the paragraph to include a reference to plats. Response: The Commission decided not to adopt the suggestions, but deferred the discussion for future consideration.

Comment: The commenter suggested adding the form number to the list of forms under Paragraph 22. Response: The Commission decided not to adopt the suggestion because if an addendum is changed, then every contract that lists the addendum would also have to be changed.

Comment: A commenter suggested extending the Lot and Block lines in all the contract forms. Response: The Commission agrees with the suggestion and has revised the forms accordingly.

Comment: Several commenters suggested putting the term "mandatory" back into the forms either where it was removed relevant to the phrase "property owners associations" (POA) or in conjunction with the POA phrase so that it is clear that the reference applies to mandatory membership in a property owners association. Response: The Commission agrees with the suggestions and has revised the relevant forms to insert "mandatory" before "membership" in Paragraph 6 of the contract forms and in TREC Form No. 36-5 and 37-3. In TREC Form No. 38-2, Paragraph 4 was changed by inserting "Property" before "Owners' Association."

Comment: One commenter suggested bolding the last sentence in Paragraph 6C(1), and moving it to be the second sentence of the paragraph. Response: The Commission did not move the sentence but agreed to bold the last sentence and has revised the relevant contract forms accordingly.

Comment: One commenter suggested changing Paragraphs 2B(2) and 2C(2) of the Residential Condominium Contract, TREC Form No. 32-2, so that buyer may cancel the contract "within five days of receipt" of the documents rather than "before the sixth day after the date Buyer receives" the documents. Response: The Commission respectfully disagrees as the text of the clauses in the referenced paragraphs tracks verbatim the statutory disclosure requirements for the documents referenced in the paragraphs.

Comment: One commenter suggested removing the "Initial" section for the seller at the bottom of page one of TREC Form No. 32-2, the Condominium Resale Certificate and TREC Form No. 37-3, Subdivision Information, Including Resale Certificate for Property Subject to Mandatory Membership in a Property Owners' Association. The BLC agrees with the suggestion and further suggested that seller's and buyer's initials should be removed from both forms. Two commenters also suggested adding a buyer signature line to Form No. 37-3 to be consistent with Form No. 32-2. Alternatively, the BLC suggested removing the buyer signature line from Form No. 32-2. Finally, the BLC suggested moving "Date _____" above the line before "Mailing Address_____" in both forms. Response: The Commission agrees with the BLC suggestions on both forms and has revised the forms accordingly.

Comment: One commenter suggested that the term "wrongfully" should be deleted from the phrase "wrongfully fails" in Paragraph 18D of the contract forms. Response: The Commission respectfully disagrees as the term "wrongfully" establishes intent in failing to release the earnest money as provided in Paragraph 18.

Comment: A commenter suggested revising TREC Form No. 37-3, Subdivision Information, Including Resale Certificate for Property Subject to Mandatory Membership in a Property Owners' Association, to address issues related to extraordinary fees charged by Property Owners' Associations. Response: The Commission agrees with the concern. However, the BLC and the Commission believe that the issue is more of a legislative issue and not a form issue.

Comment: Several commenters suggested adding a provision to allow the buyer to terminate the contract if the property appraises for less than the sales price. The BLC suggested that the Commission defer the discussion until the Third Party Financing Addendum is reviewed. Response: The Commission agrees with the BLC suggestion to defer the discussion until the Third Party Financing Addendum is reviewed.

Comment: In TREC Form No. 9-7, one commenter suggested making formatting changes in Paragraph 1 concerning the lines for the buyer and seller. Response: The Commission agrees with the suggestion and has revised the form accordingly.

Comment: One commenter suggested that in Paragraph 6C of all relevant forms, "any lender" should be struck and substituted with "Buyer's lender." The BLC agreed with the commenter's concerns and alternatively suggested that "any lender" and "Buyer's lender" should be substituted with "Buyer's lender(s)." Response: The Commission agrees with the BLC suggestions and has revised the forms accordingly.

Comment: One commenter suggests adding lines for cell phone numbers for buyers and sellers in Paragraph 21. Response: The Commission respectfully disagrees and believes that it is not necessary to include the parties' cell phone numbers in the contract forms.

Comment: One commenter suggested bolding "specific" in Paragraph 7 under "specific repairs" in all of the contract forms that mention repairs. Response: The Commission respectfully disagrees and believes that it is not necessary to bold the term.

Comment: One commenter suggested adding the Seller's Temporary Lease to the list of addenda under Paragraph 22 in the relevant contract forms. Response: The Commission agrees with the suggestion and has revised the forms accordingly.

Comment: One commenter suggested using an "x" instead of a checkmark in the pre-checked box in Paragraph 22 of TREC Form Nos. 23-8 and 24-8. Response: The Commission respectfully disagrees and believes that it is not necessary to change the forms in that manner.

Comment: In TREC Form No. 32-2, Condominium Resale Certificate, Paragraph N, one commenter suggested adding "E-mail _____." Response: The Commission agrees with the suggestions and has revised the form accordingly.

Comment: In TREC Form No. 36-5, Addendum for Property Subject to Mandatory Membership in a Property Owners' Association, one commenter suggested placing quotation marks around the phrase "Subdivision Information" to further clarify the meaning. Response: The Commission respectfully disagrees and believes that it is not necessary to change the form in that manner.

Comment: One commenter suggested adding the term "Print" before "Name" on page 2 of TREC Form No. 37-3, Subdivision Information, Including Resale Certificate for Property Subject to Mandatory Membership in a Property Owners' Association. Response: The Commission agrees with the suggestion and has revised the form accordingly.

Comment: Several commenters suggested that the contract forms include a provision for the transfer of mineral rights. The BLC suggested that the Commission defer the discussion until an appropriate addendum addressing this issue may be developed. Response: The Commission agrees with the BLC suggestion to defer the discussion until an appropriate addendum is developed.

Comment: One commenter suggested revising Paragraph 6C(1) of the contract forms to make it clearer who pays for the survey when the seller fails to provide a survey. Response: The Commission respectfully disagrees with the commenter as it believes that the paragraph is sufficiently clear that the buyer is responsible for obtaining a new survey at the seller's expense if the seller fails to furnish an existing survey or affidavit within the time prescribed. Also, as suggested by another commenter, the Commission has agreed to bold the last sentence in Paragraph 6C(1) which addresses this issue.

Comment: One commenter suggested revising Paragraph 12A(1) to include Property Owner's Association transfer fees as a seller's expense. Response: The Commission respectfully disagrees with the commenter because the issue is addressed in Paragraph B of Standard Contract Form TREC No. 36-5, Addendum for Property Subject to Mandatory Membership in a Property Owners' Association. Under Paragraph B, the buyer pays association fees resulting from the transfer not to exceed

an agreed amount and the seller pays any excess. Therefore, the parties may negotiate how much each party will pay for such transfer fees.

In addition to the changes described above, the forms adopted by reference contain the following revisions.

The amendment to §537.20 adopts by reference Standard Contract Form TREC No. 9-7, Unimproved Property Contract. The revisions are the same as those adopted in Standard Contract Form TREC No. 20-8 and further described below except for the following: Paragraph 2 is not amended, the changes referenced in Paragraph 7D in TREC No. 20-8 are made to Paragraph 7B, and a new checkbox is not added to Paragraph 22 regarding the Addendum Containing Required Notices Under §5.01, §420.001, and §420.002, Texas Property Code.

The amendment to §537.28 adopts by reference Standard Contract Form TREC No. 20-8, One to Four Family Residential Contract (Resale). Paragraph 1 is rewritten to define the parties to the contract. Paragraph 2A is reformatted and new language is added to Paragraph 2D to clarify that improvements and accessories retained by seller must be removed prior to delivery of possession. In Paragraph 5, "both" is replaced by "all" as there may be more than two parties to a contract. In Paragraph 6D, the sentence that addresses the time for buyer to object is rewritten for clarity. Paragraph 6E(2) is amended to address issues relating to "mandatory membership" in a "property owners' association" rather than a "mandatory owners' association" to track statutory language in §5.012, Texas Property Code. Also, Paragraph 6E(2) is amended to indicate that the residential community the Property is located in is identified in Paragraph 2A to conform to §5.012, Texas Property Code, and the last sentence is bolded for extra emphasis. Paragraph 7D is amended to provide checkboxes to choose whether buyer accepts property in its present condition or in its present condition with specific repairs enumerated. Under Paragraph 9, subparagraphs C and D are moved to Paragraph 19, and a new clause, (4), is added to subparagraph B regarding seller's representations. The text for the new clause is moved from Paragraph 19. Under Paragraph 12A(1)(b), the reference to the Veterans Housing Assistance Program is changed to a reference to the Texas Veterans Land Board because there are more than one loan programs available from the Veterans Land Board. Paragraph 17 is amended to substitute "Buyer, Seller, Listing Broker, Other Broker or escrow agent who prevails" for "The prevailing party" to clarify that the attorney fee provision applies to all of the named persons and not just the parties to the contract. Paragraph 18D is amended to clarify that damages for wrongfully failing or refusing to sign a release of earnest money include the sum of the earnest money, three times the earnest money, reasonable attorney's fees and all costs of suit. Paragraph 19 is revised to add text that was deleted from subparagraphs 9(C) and (D). Paragraph 22 is revised to add a checkbox for the Addendum Containing Required Notices Under §5.01, §420.001, and §420.002, Texas Property Code, and to revise the title of the Addendum for Property Subject to Mandatory Membership in a Property Owners' Association. Paragraph 23 is amended to clarify that if the buyer fails to pay the Option Fee to seller within the time prescribed, the option paragraph will not be a part of the contract. Currently, it is not clear that the buyer must pay the Option Fee to seller.

The amendment to §537.30 adopts by reference Standard Contract Form TREC No. 23-8, New Home Contract (Incomplete Construction). The revisions are the same as those adopted in Standard Contract Form TREC No. 20-8 described above except for the following: Paragraph 2 is not amended; Paragraph 6D is not amended; Paragraph 7D is not amended; the checkbox added to Paragraph 22 regarding the Addendum Containing Required Notices Under §5.01, §420.001, and §420.002, Texas Property Code is pre-checked and a parenthetical is included to explain that the addendum must be attached and Paragraphs B and C must be completed.

The amendment to §537.31 adopts by reference Standard Contract Form TREC No. 24-8, New Home Contract (Completed Construction). The revisions are the same as those adopted in Standard Contract Form TREC No. 20-8 described above except for the following: Paragraph 2 is not amended; Paragraph 6D is not amended; Paragraph 7D is not amended; the checkbox added to Paragraph 22 regarding the Addendum Containing Required Notices Under §5.01, §420.001, and §420.002, Texas Property Code is pre-checked and a parenthetical is included to explain that the addendum must be attached and Paragraphs B and C must be completed.

The amendment to §537.32 adopts by reference Standard Contract Form TREC No. 25-6, Farm and Ranch Contract. The revisions are the same as those adopted in Standard Contract Form TREC No. 20-8 except for the following: Paragraph 2E is amended rather than Paragraph 2D; Paragraph 6D is not amended; and Paragraph 6E2 is not amended.

The amendment to §537.37 adopts by reference Standard Contract Form TREC No. 30-7, Residential Condominium Contract (Resale). The revisions are the same as those adopted in Standard Contract Form TREC No. 20-8 described above except as follows: Paragraph 6C is amended rather than 6D regarding the time for buyer to object; Paragraph 6E2 is not amended; Paragraph 22 is not amended.

The amendment to §537.39 adopts by reference Standard Contract Form TREC No. 32-2, Condominium Resale Certificate. The revisions are nonsubstantive in nature and conform Paragraph N and the signature block of the form with TREC No. 37-3, Subdivision Information, Including Resale Certificate for Property Subject to Mandatory Membership in a Property Owners' Association.

The amendment to §537.43 adopts by reference Standard Contract Form TREC No. 36-5, Addendum for Property Subject to Mandatory Membership in a Property Owners' Association. The title of the form is changed to conform to §5.012, Texas Property Code; the term "property" is substituted for "mandatory" to more accurately reflect the terminology in §5.012, Texas Property Code; and the term "owners'" is deleted from Paragraph B and the last paragraph.

The amendment to §537.44 adopts by reference Standard Contract Form TREC No. 37-3, Subdivision Information, Including Resale Certificate for Property Subject to Membership in a Property Owners' Association. The title of the form is changed to conform to §5.012, Texas Property Code; the parenthetical below the title is amended to read "Chapter 207, Texas Property Code"; the term "owners'" is deleted from various provisions in the form; another line is added near the end of the form for the name of the person signing the form.

The amendment to §537.45 adopts by reference Standard Contract Form TREC No. 38-2, Notice of Buyer's Termination of Contract. The termination notice is modified to serve as an all purpose buyer's notice of termination to be used under various circumstances detailed in the form including but not lim-

ited to notifying the seller that: The contract is terminated under Paragraph 23; Buyer cannot obtain Financing Approval; Property does not satisfy the lenders' underwriting requirements for the loan; Buyer elects to termination under Paragraph A of the Addendum for Property Subject to Mandatory Membership in a Property Owners' Association; Buyer elects to terminate under Paragraph 7B(2) of the contract; or that Buyer is terminating pursuant to a specific paragraph in the contract or addendum to be identified in the form.

The amendments and forms are adopted under Texas Occupations Code, §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapter 1101; and to establish standards of conduct and ethics for its licensees to fulfill the purposes of Chapter 1101 and ensure compliance with Chapter 1101.

The statute affected by this proposal is Texas Occupations Code, Chapter 1101. No other statute, code or article is affected by the adopted amendments.

§537.20. Standard Contract Form TREC No. 9-7.

The Texas Real Estate Commission adopts by reference standard contract form TREC No. 9-7 approved by the Texas Real Estate Commission in 2008 for use in the sale of unimproved property where intended use is for one to four family residences. This document is published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188, www.trec.state.tx.us.

§537.28. Standard Contract Form TREC No. 20-8.

The Texas Real Estate Commission adopts by reference standard contract form TREC No. 20-8 approved by the Texas Real Estate Commission in 2008 for use in the resale of residential real estate. This document is published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188, www.trec.state.tx.us.

§537.30. Standard Contract Form TREC No. 23-8.

The Texas Real Estate Commission adopts by reference standard contract form TREC No. 23-8 approved by the Texas Real Estate Commission in 2008 for use in the sale of a new home where construction is incomplete. This document is published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188, www.trec.state.tx.us.

§537.31. Standard Contract Form TREC No. 24-8.

The Texas Real Estate Commission adopts by reference standard contract form TREC No. 24-8 approved by the Texas Real Estate Commission in 2008 for use in the sale of a new home where construction is completed. This document is published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188, www.trec.state.tx.us.

§537.32. Standard Contract Form TREC No. 25-6.

The Texas Real Estate Commission adopts by reference standard contract form TREC No. 25-6 approved by the Texas Real Estate Commission in 2008 for use in the sale of a farm or ranch. This document is published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188, www.trec.state.tx.us.

§537.37. Standard Contract Form TREC No. 30-7.

The Texas Real Estate Commission adopts by reference standard contract form TREC No. 30-7 approved by the Texas Real Estate Commission in 2008 for use in the resale of a residential condominium unit. This document is published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188, www.trec.state.tx.us.

§537.39. Standard Contract Form TREC No. 32-2.

The Texas Real Estate Commission adopts by reference standard contract form TREC No. 32-2 approved by the Texas Real Estate Commission in 2008 for use as a condominium resale certificate. This document is published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188, www.trec.state.tx.us.

§537.43. Standard Contract Form TREC No. 36-5.

The Texas Real Estate Commission adopts by reference standard contract form TREC No. 36-5 approved by the Texas Real Estate Commission in 2008 for use as an addendum to be added to promulgated forms in the sale of property subject to mandatory membership in a property owners' association. This document is published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188, www.trec.state.tx.us.

§537.44. Standard Contract Form TREC No. 37-3.

The Texas Real Estate Commission adopts by reference standard contract form TREC No. 37-3 approved by the Texas Real Estate Commission in 2008 for use as a resale certificate when the property is subject to mandatory membership in a property owners' association. This document is published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188, www.trec.state.tx.us.

§537.45. Standard Contract Form TREC No. 38-2.

The Texas Real Estate Commission adopts by reference standard contract form TREC No. 38-2 approved by the Texas Real Estate Commission in 2008 for use as a notice of termination of contract. This document is published by and available from the Texas Real Estate Commission, P.O. Box 12188, Austin, Texas 78711-2188, www.trec.state.tx.us.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803476
Loretta R. DeHay
Assistant Administrator and General Counsel
Texas Real Estate Commission
Effective date: September 1, 2008
Proposal publication date: May 16, 2008
For further information, please call: (512) 465-3900

22 TAC §537.49

The Texas Real Estate Commission (TREC) adopts the repeal of §537.49 concerning standard contract form TREC No. 42-0, Notice Pursuant to Third Party Financing Condition Addendum, in connection with the anticipated adoption of revised contract forms, without changes to the published text as proposed in the May 16, 2008, issue of the *Texas Register* (33 TexReg 3885) and will not be republished.

Section 535.49 concerns a form promulgated for use as a notice that buyer cannot obtain financing pursuant to the Third Party Financing Condition Addendum. An amendment to the Notice of Buyer's Termination of Contract, TREC No. 38-2, otherwise adopted in this issue of the *Texas Register*, provides the same notice. Therefore, this notice form is no longer needed.

No comments were received on the proposed repeal.

The repeal is adopted under Texas Occupations Code, §1101.151, which authorizes the Texas Real Estate Commission

to adopt and enforce rules necessary to administer Chapter 1101; and to establish standards of conduct and ethics for its licensees to fulfill the purposes of Chapter 1101 and ensure compliance with Chapter 1101.

The statute affected by this adoption is Texas Occupations Code, Chapter 1101. No other statute, code or article is affected by the adopted repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803470
Loretta R. DeHay
Assistant Administrator and General Counsel
Texas Real Estate Commission
Effective date: September 1, 2008
Proposal publication date: May 16, 2008
For further information, please call: (512) 465-3900

♦ ♦ ♦

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 7. CORPORATE AND FINANCIAL REGULATION

The Commissioner of Insurance adopts the repeal of §§7.8, 7.15, 7.27, 7.71, 7.613, 7.1012, and 7.1701 - 7.1711, concerning corporate and financial regulation. The repeals are adopted without changes to the proposal as published in the April 18, 2008, issue of the *Texas Register* (33 TexReg 3158). Insurance Code §§404.005(a)(2), 492.055(c), 493.054(c), 802.001, 802.052, 843.151, and 843.155 were added to this adoption order as additional statutory authority for the repeal of the sections.

REASONED JUSTIFICATION. Repeal of §7.8, concerning annual statement filing instructions for county mutual insurance companies, is necessary because it is superseded by 28 TAC §7.7(f), concerning insurer accounting requirements for subordinated indebtedness. Repeal of §7.15, concerning premium taxes in Insurance Code §982.114, is necessary because the Department no longer collects premium taxes, and the functions of administering, collecting, and enforcing these premium taxes are the responsibility of the Comptroller of Public Accounts pursuant to the Insurance Code §201.051. Repeal of §7.27, concerning the regulation of accounting for reinsurance agreements by life, accident and health, and annuity insurers, is necessary to eliminate a redundancy between §7.27 and §7.18, and the potential for conflicting interpretations. The substantive provisions of §7.27 are contained in Statement of Statutory Accounting Principle No. 61 and Appendix A-791, which are part of The Accounting Practices and Procedures Manual (Manual) published by the National Association of Insurance Commissioners and adopted by reference in §7.18. Repeal of §7.71, concerning requirements for filing quarterly and annual statements, is necessary because the 2001 quarterly and 2001 annual statements and other reports adopted under the section have been filed and the due dates for such filings have passed. Repeal of §7.613, concerning reinsurance ceded to nonlicensed reinsurers during the transitional period (from September 1, 1989 to the inception, anniversary, or renewal date not less than four months after September 1, 1989), is necessary because the transitional period has expired, and therefore, there no longer is a need for this rule. The repeal of §7.1012, concerning the 2006 foreign and domestic insurance company examination assessments, is adopted because the due dates for filing the overhead assessments assessed under the section have passed; therefore, the repealed section is no longer necessary. Repeal of §§7.1701 - 7.1711, concerning taxation of administrative services, is necessary because the enactment of House Bill 3315, 80th Legislature, Regular Session, effective June 15, 2007, repealed the administrative service tax under Insurance Code Article 4.11A, and thus, the Department no longer needs these rules to administer this tax function. The Department identified these sections for repeal as part of the Department's ongoing review of existing rules pursuant to Government Code §2001.039.

HOW THE SECTIONS WILL FUNCTION. The adoption of the repeal will result in the removal of obsolete and potentially confusing provisions from the Texas Administrative Code.

SUMMARY OF COMMENTS. The Department did not receive any comments on the proposed repeal.

SUBCHAPTER A. EXAMINATION AND FINANCIAL ANALYSIS

28 TAC §§7.8, 7.15, 7.27, 7.71

STATUTORY AUTHORITY. The repeal is adopted pursuant to the Insurance Code §§404.005(a)(2), 492.055(c), 493.054(c), 802.001, 802.052, 843.151, 843.155, and 36.001. Section 404.005(a)(2) authorizes the Commissioner to establish standards for evaluating the financial condition of an insurer. Sections 492.055(c) and 493.054(c) authorize the Commissioner to adopt reasonable rules relating to the accounting and financial statement requirements of this section and the treatment of reinsurance contracts between insurers, including minimum risk transfer standards, asset debits or credits, reinsurance debits or credits, and reserve debits or credits relating to the transfer of all or any of an insurer's risks or liabilities by reinsurance contracts; and any contingencies arising from reinsurance contracts. Sections 802.001 and 802.052 authorize the Commissioner, as necessary to obtain an accurate indication of the company's condition and method of transacting business, to change the form of any annual statement required to be filed by any kind of insurance company. Section 843.151 authorizes the Commissioner to promulgate rules as are necessary to carry out the provisions of Chapter 843 of the Insurance Code (Health Maintenance Organizations). Section 843.155 requires Health Maintenance Organizations to file annual reports with the Commissioner, which include financial statements of the Health Maintenance Organizations, certified by independent public accountants. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803472
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: July 23, 2008
Proposal publication date: April 18, 2008
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER F. REINSURANCE

28 TAC §7.613

STATUTORY AUTHORITY. The repeal is adopted pursuant to the Insurance Code §§404.005(a)(2), 492.055(c), 493.054(c), 802.001, 802.052, 843.151, 843.155, and 36.001. Section 404.005(a)(2) authorizes the Commissioner to establish standards for evaluating the financial condition of an insurer. Sections 492.055(c) and 493.054(c) authorize the Commissioner to adopt reasonable rules relating to the accounting and financial statement requirements of this section and the treatment of reinsurance contracts between insurers, including minimum risk transfer standards, asset debits or credits, reinsurance debits or credits, and reserve debits or credits relating to the transfer of all or any of an insurer's risks or liabilities by reinsurance contracts; and any contingencies arising from reinsurance contracts. Sections 802.001 and 802.052 authorize the Commissioner, as necessary to obtain an accurate indication of the company's condition and method of transacting business, to change the form of any annual statement required to be filed by any kind of insurance company. Section 843.151 authorizes the Commissioner to promulgate rules as are necessary to carry out the provisions of Chapter 843 of the Insurance Code (Health Maintenance Organizations). Section 843.155 requires Health Maintenance Organizations to file annual reports with the Commissioner, which include financial statements of the Health Maintenance Organizations, certified by independent public accountants. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803473
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: July 23, 2008
Proposal publication date: April 18, 2008
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER J. EXAMINATION EXPENSES AND ASSESSMENTS

28 TAC §7.1012

STATUTORY AUTHORITY. The repeal is adopted pursuant to the Insurance Code §§404.005(a)(2), 492.055(c), 493.054(c), 802.001, 802.052, 843.151, 843.155, and 36.001. Section 404.005(a)(2) authorizes the Commissioner to establish standards for evaluating the financial condition of an insurer. Sections 492.055(c) and 493.054(c) authorize the Commissioner to adopt reasonable rules relating to the accounting and financial statement requirements of this section and the treatment of reinsurance contracts between insurers, including minimum risk transfer standards, asset debits or credits, reinsurance debits or credits, and reserve debits or credits relating to the transfer of all or any of an insurer's risks or liabilities by reinsurance contracts; and any contingencies arising from reinsurance contracts. Sections 802.001 and 802.052 authorize the Commissioner, as necessary to obtain an accurate indication of the company's condition and method of transacting business, to change the form of any annual statement required to be filed by any kind of insurance company. Section 843.151 authorizes the Commissioner to promulgate rules as are necessary to carry out the provisions of Chapter 843 of the Insurance Code (Health Maintenance Organizations). Section 843.155 requires Health Maintenance Organizations to file annual reports with the Commissioner, which include financial statements of the Health Maintenance Organizations, certified by independent public accountants. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803474
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: July 23, 2008
Proposal publication date: April 18, 2008
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER Q. TAXATION OF ADMINISTRATIVE SERVICES

28 TAC §§7.1701 - 7.1711

STATUTORY AUTHORITY. The repeal is adopted pursuant to the Insurance Code §§404.005(a)(2), 492.055(c), 493.054(c), 802.001, 802.052, 843.151, 843.155, and 36.001. Section 404.005(a)(2) authorizes the Commissioner to establish standards for evaluating the financial condition of an insurer. Sections 492.055(c) and 493.054(c) authorize the Commissioner to adopt reasonable rules relating to the accounting and financial statement requirements of this section and the treatment of reinsurance contracts between insurers, including minimum risk transfer standards, asset debits or credits, reinsurance debits or credits, and reserve debits or credits relating to the transfer of all or any of an insurer's risks or liabilities by reinsurance contracts; and any contingencies arising from reinsurance contracts. Sections 802.001 and 802.052 authorize the Commissioner, as necessary to obtain an accurate indication of

the company's condition and method of transacting business, to change the form of any annual statement required to be filed by any kind of insurance company. Section 843.151 authorizes the Commissioner to promulgate rules as are necessary to carry out the provisions of Chapter 843 of the Insurance Code (Health Maintenance Organizations). Section 843.155 requires Health Maintenance Organizations to file annual reports with the Commissioner, which include financial statements of the Health Maintenance Organizations, certified by independent public accountants. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803475
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: July 23, 2008
Proposal publication date: April 18, 2008
For further information, please call: (512) 463-6327

♦ ♦ ♦

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 133. GENERAL MEDICAL PROVISIONS

SUBCHAPTER A. GENERAL RULES FOR MEDICAL BILLING AND PROCESSING

28 TAC §§133.2, 133.4, 133.5

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §133.2, concerning definitions. The Commissioner also adopts new §133.4, concerning notification to healthcare providers of contractual agreements between insurance carriers and informal networks and/or voluntary networks, and new §133.5, concerning informal network and voluntary network reporting requirements to the Division. The amended and new sections are adopted with changes to the proposed text as published in the March 7, 2008, issue of the *Texas Register* (33 TexReg 1992).

The amendments to §133.2 are necessary to update existing rule definitions, and citations, and to add definitions recently enacted by Labor Code §413.0115. Adopted §133.4 is necessary to comply with Labor Code §413.011(d-2), effective September 1, 2007, which was enacted by House Bill (HB) 473, 80th Legislature, Regular Session. Pursuant to Labor Code §413.011(d-1), an insurance carrier or the insurance carrier's authorized agent may use an informal or voluntary network, as those terms are defined by Labor Code §413.0115, to obtain a contractual fee agreement that provides fees that are different from the Division's fee guidelines. In order to provide increased transparency of insurance carrier contractual fee arrangements with informal and voluntary networks, Labor Code §413.011(d-2) requires the Commissioner by rule to establish the time and manner by which an informal or voluntary network, or the insurance carrier or the insurance carrier's authorized agent, must provide notice to each affected health care provider. The notice must inform the health care provider of any person that is given access to the health care provider's contractual fee arrangement with the informal or voluntary network. Labor Code §413.011(d-2) does not limit the duty of providing the notice to one entity but requires the informal or voluntary networks or insurance carrier, or insurance carrier agent, to give notice to health care providers of any access to their contractual agreements. To remain consistent with the statutory provisions of Labor Code §413.011(d-2), new §133.4 specifies the time and manner of providing notice to the health care provider and allows the insurance carrier, the insurance carrier's authorized representative, or the informal or voluntary network the flexibility to determine which entity will provide the requisite notice to affected health care providers. This flexibility in adopted §133.4 allows the insurance carrier, the insurance carrier's authorized agent, or the informal or voluntary network to deliver and document the notice using whatever method best fits its business needs, so long as the notice contains the requisite information, is delivered in accordance with the stated timeframes, and can be reproduced at the request of the Division. Notice by certified mail is not prohibited by adopted §133.4. However, due to the potential volume of notices that may become necessary pursuant to Labor Code §413.011(d-2) and the Division's recognition of substantial costs associated with providing notice by certified mail to affected health care providers, adopted §133.4 does not restrict notice to this one method of delivery.

Adopted §133.5 is necessary to specify additional reporting requirements by informal networks and voluntary networks to the Division and to include the reporting requirements established by Labor Code §413.0115.

The Division posted an informal draft of the amendments to §133.2, new §133.4, and new §133.5 on the Department's website on November 6, 2007. The Division published the proposed text of the amended and new sections in the March 7, 2008, issue of the *Texas Register*.

In response to written comments received from interested parties and for the purpose of clarity, the Division has changed some of the proposed language in the text of the rule as adopted. The changes, however, do not introduce new subject matter or affect persons in addition to those subject to the proposal as published. Section 133.2. In paragraphs (1) and (6), the Division has added the terms "the Insurance Code" and "Department," deleted the term "or" before "Division" and added the term "or" after Division. These changes from proposal are necessary because an insurance carrier's responsibilities for claims services functions, including medical bill processing, are broad in the workers' compensation system, and include, compliance by an insurance carrier, and its agents, with all applicable provisions in the Insurance Code, the Labor Code, Division, and/or Department rules.

Section 133.4. Adopted subsection (a), regarding applicability was added as a result of public comments requesting clarification that this section applies to contracted fees that are negotiated by an informal or voluntary network and is not applicable to payments made under a certified health care network agreement

pursuant to Insurance Code Chapter 1305. Due to the addition of an applicability provision in subsection (a), the subsequent subsections were renumbered. In subsection (b), the additional language of "insurance carrier" is a change from proposal as a result of public comments to clarify that an insurance carrier could satisfy the definition of "person" in this subsection for compliance with the notice requirements. Specifically, if an informal or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed to an insurance carrier, the insurance carrier would satisfy the definition of "person" in subsection (b). For the purpose of clarity, the Division changed from proposal the subsection (c) subheading from "Required Notification" to "Required Notice." In adopted subsection (c), the deletion of ", including, but not limited to, any person to whom the informal or voluntary network's fee arrangement with that health care provider is sold, leased, transferred, or conveyed," is also a change from proposal in response to public comments to delete the varying language for the meaning of "person" in proposed subsection (b). Some commenters recommended referring to the definition of "person" in an effort to avoid confusion and perceived inconsistencies about the meaning of the term "person" as it relates to when notice is required.

For the purpose of clarity, the Division changed from proposal the subsection (d) subheading from "Content of notification" to "Notice." Also for clarification, the Division deleted "Notification" and "shall include" and replaced those terms so that the initial phrase for subsection (d) states "Notice to each contracted health care provider." Adopted (d)(1) has changed from proposal for the purpose of clarity and to specify the type of contact information required in the notice to each contracted health care provider for the informal or voluntary network. Adopted (d)(1) adds "must include the" and ", but not limited to, the name, physical address." These changes clarify that the contact information in the notice must also include the name of the informal or voluntary network and the physical address. With the additional language of "but not limited to" the sender of the notice may additionally include such contact information as the informal or voluntary network's fax number or email address. However, this change from proposal specifies that, at a minimum, the notice must include the name of the informal or voluntary network, the physical address, and a toll-free telephone number.

For the purpose of clarity and in response to public comments, subsection (d)(2) includes changes from proposal. Specifically, the Division added "must include" in subsection (d)(2). In subsection (d)(2)(A), the Division found it necessary to make changes from proposal to clarify the type of contact information that is required when the sender of the notice informs the health care provider that a person is given access to the informal or voluntary network's fee arrangement with a health care provider. Specifically, subsection (d)(2)(A) adds "name, physical address, and telephone number" and deletes "contact information." In addition, in response to public comments, the Division deleted "and identification," "insurance carrier, or other" and "including, but not limited to, any person to whom the informal or voluntary network's fee arrangement with the health care provider is sold, leased, transferred, or conveyed." Since subsection (b) defines "person" and clarifies that an insurance carrier would satisfy the definition of "person" if an informal or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed to an insurance carrier, the changes from proposal in adopted subsection (d)(2)(A) are necessary to avoid possible inconsistencies and confusion about the meaning of "person" as it relates to notice.

The Division renumbered this subsection from §133.4(d) to §133.4(d)(3) for the purpose of clarity. Adopted subsection (d)(3) has further changed for clarification which include deleting "Method of Notification" as the subsection heading and deleting the phrase "[t]he information listed in subsection (c) of this section." An additional change in adopted subsection (d)(3) includes deleting the phrase "[A] link to a website may be provided only if the website:" to place a portion of that phrase in renumbered subsection (d)(4). Clarification changes were made in adopted subsection (d)(4), the phrase "to a website may be provided" was deleted and the phrase "may be provided through a website link only if the website:" was added. Adopted subsection (d)(4)(A) and (B) are re-numbered subsections from proposal. Adopted subsection (d)(4)(A) is structurally revised to add "(d)(1)" and the renumbered "(d)(2)(A)" and "(d)(2)(B)." Adopted subsection (d)(4)(B) has changed since proposal due to public comments requesting that the Division delete the word "and," add the phrase "with current and correct information," and delete proposed subsection (d)(3). Commenters expressed concern that, although proposed subsection (d)(2) recognized the need to periodically update the website information available to health care providers, proposed subsection (d)(3) suggested that the information on the website must always be current and correct. The Division clarifies with the change to subsection (d)(4)(B) that, at the very least, a monthly update of the sender's webpage with current and correct information is expected. Accordingly, the Division deleted proposed (d)(3) which stated "contains current and correct information."

Adopted subsection (e) has changed since proposal to add "information provided," and "as required by subsection (d)," as well as deleting the phrase "content of the notice" due to the change in subsection (d) from "Content of Notification" to "Notice." Further changes since proposal in adopted subsection (e) were made in response to a written comment. The words "method of" were added and the words "of the notice" were deleted. Further, the sentence "[f]or the purpose of this section, a notice is determined to be delivered in accordance with §102.4(p)" was added. In response to a written comment that it is often difficult to pinpoint the actual delivery date, these changes from proposal are necessary in order for the sender to document the manner in which the notice was provided to affected health care providers and the date of delivery. To determine the date that a notice is delivered to an affected health care provider, this change makes clear that the sender should refer to the existing Division rule §102.4(p) for the purpose of determining the date of receipt.

Changes from proposal were made in adopted subsection (f)(1) and (f)(2) due to the later than anticipated date of this section's adoption. The Division has deleted the terms "June" and "September" and replaced them with "August" and "November" in adopted subsection (f)(1). As explained in the proposal for subsection (f)(1), a period of ninety days should provide the informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent with sufficient time to determine which entity will provide the initial notice for contracts in effect on August 1, 2008. Accordingly, the Division has deleted the word "June" and replaced it with the term "August" in subsection (f)(2).

In response to written comments suggesting that the proposed subsection could mistakenly be interpreted to apply to payments made under a certified healthcare network, the Division added to subsection (g), the phrase "negotiated by an informal network or voluntary network." For the purpose of clarity and to remain con-

sistent with Labor Code §413.011 and subsection (c), which require the sender of the notice to do so within the time and manner provided by this section, the Division deleted proposed subsection (g)(1), which stated "the notice to the health care provider does not meet the criteria outlined in subsection (c)(2)(A) and (c)(2)(B) of this section; or" and the terms "subsections (b) - (f)." Due to the changes, the Division re-numbered subsection (g). In response to written comments requesting that the Division provide guidance on reimbursement in the absence of an applicable Division fee guideline, adopted subsection (h) has been changed since proposal to add "pursuant to §134.1(e)(1), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable pursuant to §134.1(e)(3)."

Changes since proposal were made to adopted subsection (i) for the purpose of clarity. The Division deleted the term "notification" and replaced it with the term "notice." Additionally, for the purpose of clarity and to remain consistent with Labor Code §413.011 and adopted subsection (c), which require the sender of the notice to send notice within the time and manner provided by this section, the Division deleted the phrase "of subsections (b) - (e)."

Another change made since proposal is in subsection (j) to clarify and add the subheading title "Severability Clause."

Similarly, a change since proposal was made to adopted subsection (k) for the purpose of clarity and consistency throughout the section. This change was the addition of the subheading title "Expiration." In response to written comments suggesting that proposed subsection (k) may create confusion in 2011 as to whether or not there is any rule in place to assist in deciding unresolved fee disputes over services rendered prior to January 1, 2011, the Division added "[t]his section will continue to apply to health care services rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider."

Section 133.5. Due to the later than anticipated adoption of this section, the Division made a change to adopted subsection (c) since proposal. Specifically, the Division deleted the term "June" and replaced it with "August." For the purpose of clarity, the Division made a change to adopted subsection (e) by adding "informal and voluntary network" and deleting "to the Division."

Amendments to §133.2, concerning definitions are adopted for Subchapter A, General Rules for Medical Billing and Processing. New §133.4(a) states that the section applies to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider in accordance with Labor Code §413.011 and §413.0115. Subsection (b) defines the term "person" under the section and specifies that the term "person" does not include an injured employee. Subsection (c) specifies the required notice by an informal network or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, to each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider within the time and manner provided by this section. Subsection (d) establishes the information required in the notice to each contracted health care provider. Specifically, subsection (d)(1) states that notice to each contracted health care provider must include the contact information for the informal or voluntary network, including, but not limited to, the name, address, and a toll-free telephone number accessible to all contracted health care providers. In addition, subsection (d)(2)(A) and (d)(2)(B) further require that notice to each contracted health care provider must include specific information in the body of the notice. Such information includes the name, address, and telephone number of any person that is given access to the informal or voluntary network's fee arrangement with a health care provider, and the start date and any end date during which any person has been given access to the health care provider's fee arrangement. Subsection (d)(3) provides that notice to each contracted health care provider may be provided in an electronic format provided a paper version is available upon request by the Division. In addition, subsection (d)(4)(A) and (d)(4)(B) provide that notice to each contracted health care provider may be provided through a website link only if the website link contains the information stated in subsection (d)(1), (d)(2)(A), and (d)(2)(B) of this section and is updated at least monthly with current and correct information. Subsection (e) provides that the informal or voluntary network, insurance carrier or the insurance carrier's authorized agent, as appropriate, shall document the information provided in the notice as required by subsection (d), the method of delivery, to whom the notice was delivered, and the date of the delivery. Subsection (e) further provides that for purposes of this section, a notice is determined to be delivered in accordance with §102.4(p). Additionally, subsection (e) states that failure to provide documentation upon the request of the Division or failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable presumption in a Division enforcement action or in a medical fee dispute that the health care provider did not receive the notice. Subsection (f) provides for the time of notification. Subsection (f)(1) states that for contracts with health care providers in effect on August 1, 2008, initial notification must be made no later than November 1, 2008, and subsequent notices to health care providers in accordance with this section shall occur thereafter on a quarterly basis. Subsection (f)(2) provides that for contracts with health care providers entered into after August 1, 2008, initial notification must be made no later than the 30th day after the effective date of the contract and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis.

Subsection (g) provides that the insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115. Subsection (h) provides that if the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3).

Subsection (i) provides that if notice to the health care provider does not meet the requirements of this section, the insurance carrier may be held liable for administrative violations in accordance with Labor Code provisions and Division rules. Section (j) contains a severability clause stating that if a court of competent jurisdiction holds that any provision of the section is inconsistent with any statutes of this state, is unconstitutional, or is found to be invalid for any reason, the remaining provisions of this section shall remain in effect. Subsection (k) provides that in accordance with Labor Code §413.011(d-6), the provisions of the rule shall expire on January 1, 2011. Subsection (k) further provides

that the section will continue to apply to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider.

New §133.5(a) provides for the reporting requirements and states that each informal network and voluntary network must provide the following information to the Division: (1) the informal network or voluntary network's name and federal employer identification number (FEIN); (2) an executive contact for official correspondence for the informal or voluntary network; (3) a toll-free telephone number by which a health care provider may contact the informal network or voluntary network; (4) a list of each insurance carrier with whom the informal network or voluntary network contracts, including the insurance carrier's FEIN; and, (5) a list of each entity or insurance carrier agent associated with the informal or voluntary network working on behalf of the insurance carrier, including contact information for each entity.

Subsection (b) provides for the reporting format and states that reports, including changes, must be submitted through the Division's on-line reporting system accessible through the Division's website at www.tdi.state.tx.us. Subsection (c) provides that each informal network and voluntary network that has a contract with an insurance carrier or an insurance carrier's authorized agent in effect on September 1, 2007, must report to the Division in accordance with this section no later than August 1, 2008. Subsection (c) further provides that except as provided in the subsection, informal and voluntary networks must report to the Division no later than the 30th day after the effective date of a contract signed with an insurance carrier or an insurance carrier's authorized agent.

Subsection 133.5(d) provides that each informal network and voluntary network shall report any changes to the information provided under subsection (a) of the section to the Division not later than the 30th day after the effective date of the change in accordance with Labor Code §413.0115 and the section. Subsection 5(e) provides that if the informal and voluntary report does not meet the requirements of Labor Code §413.0115 and this section, the informal network or voluntary network may be held liable for any administrative violations. Subsection (f) provides that the provisions of this rule shall expire on January 1, 2011.

Section 133.2(6): A commenter states that the proposed definition of "insurance carrier agent" seems to include medical bill processing within the category of claims services. The commenter recommends revising the language to more clearly distinguish the two since medical bill processing and claims services are mutually exclusive functions.

Agency Response: The Division does not agree that a revision of §133.2(6) for the purpose of distinguishing medical bill processing functions from claims services function is necessary. Medical bill processing is a claims services function. Any person or entity with whom the workers' compensation insurance carrier contracts or utilizes on its behalf to provide any claims services function, including medical bill processing, pursuant to the Labor Code, Insurance Code, Division or Department rules is considered an insurance carrier agent. Because an insurance carrier's responsibilities for claims services functions, including medical bill processing, are broad in the workers' compensation system, the Division has added language to the definitions of "bill review" in §133.2(1) and "insurance carrier agent" in §133.2(6) to clarify that an insurance carrier and its agents must comply with all applicable provisions in the Labor Code, the Insurance Code, Division or Department rules.

Section 133.4: A commenter recommends that the rules for informal networks and voluntary networks, and any associated rules provide as much flexibility as possible to allow contracts between insurance carriers and informal networks or voluntary networks to specify which entity will assume the responsibilities for the mandates set out in statutory requirements that govern the use of informal and voluntary network agreements with insurance carriers and health care providers. The commenter recommends that the proposed rules do not micromanage any portion of the new insurance carrier contract provisions with informal or voluntary networks and informal or voluntary network contract provisions with health care provider contracting provisions as amended by HB 473.

Agency Response: The Division agrees that if a carrier or the carrier's authorized agent chooses to use an informal or voluntary network to obtain a contractual agreement that provides for fees different from the Division's fee guidelines, Labor Code §413.011(d-2) would require an informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, to notify each health care provider of any person that is given access to the fee arrangement within the time and manner of this new section. New §133.4(c) allows the insurance carrier, the insurance carrier's authorized agent, or the informal or voluntary network, the flexibility to determine which entity will provide the notice to affected health care providers, as well as the flexibility to deliver and document the notice using whatever method best fits its business needs so long as the notice contains the requisite information, is delivered in accordance with the stated timeframes, and can be reproduced at the request of the Division.

Section 133.4: A commenter describes its organization as a nonprofit entity governed by a professional medical association with a medical board of directors. This entity does not require its providers to send their bills to them. The commenter explains that several insurance companies have contracted with it to obtain the credentialing information to become certified. The commenter explains that it does not provide the credentialing for them but only tries to negotiate on the provider's behalf to obtain the best possible rates from the carriers. The commenter further states that it submits to the insurance carriers all of the credentialing applications for every provider that agrees to accept the rates offered to its group. Each provider bills and gets paid by the insurance carrier and the commenter does not get involved or charge a percentage from the carriers or providers. Commenter questions whether it is an informal or voluntary network based on the information it has provided.

Agency Response: The commenter appears to be requesting that the Division confirm whether the commenter's operations constitute an informal or voluntary network. The Texas Department of Insurance, Division of Workers' Compensation, as a regulatory agency, is not authorized to render legal opinions or advice regarding a specific factual scenario. However, the Division points out that Labor Code §413.0115 and Division rule §134.2 define an "informal network" as "a health care provider network described by Labor Code §413.011(d-1) that: (A) is established under a contract between an insurance carrier and health care providers; and (B) includes a specific fee schedule. In addition, a "voluntary network" is defined as "a voluntary workers' compensation health care delivery network established by an insurance carrier under former Labor Code §408.0223, as that section existed before repeal by Chapter 265, Acts of the 79th Legislature."

Section 133.4: A commenter states that the informal networks and voluntary networks have operated with essentially no regulation. Because of the business practices used by some of the informal and voluntary networks, health care providers have had difficulty obtaining information needed to determine whether the reimbursement received was appropriate for the treatment provided to injured employees. The commenter states that HB 473 was adopted to address this concern.

Agency Response: The Division appreciates the comment and agrees that HB 473, codified at Labor Code §413.011(d-1), clarifies the law authorizing deviations from the medical fee guidelines. Labor Code §413.011(d-1) and (d-2) require certain contractual arrangements and notification requirements to health care providers should an insurance carrier or the carrier's authorized agent seek to use an informal or voluntary network to obtain a contractual agreement that provides for fees different from the fees authorized under the Division's fee guidelines.

Section 133.4: A commenter states that the Division should specifically clarify that these provisions do not apply to pharmacy benefit management programs. The commenter explains that pharmaceutical services are specifically excluded from networks certified under Chapter 1305 of the Insurance Code. The commenter further states that since voluntary networks and informal networks are required to be certified in accordance with Chapter 1305 by 2011, it serves to reason that these rules should not apply to pharmaceutical providers.

Agency Response: The Division clarifies that this section applies to any contractual agreement between an insurance carrier, or the insurance carrier's authorized agent, and an informal or voluntary network, and a health care provider, that provides for fees different from the fees authorized under the Division's fee guidelines pursuant to Labor Code §413.011(d-1). The Division agrees that pursuant to Labor Code §413.0115(b), not later January 1, 2011, each informal network or voluntary network must be certified as a workers' compensation health care network under Chapter 1305, Insurance Code. The Division further agrees that prescription medication or services, as defined by Labor Code §401.011(19)(E), may not be delivered through a workers' compensation health care network under Insurance Code §1305.101(c), but, are instead, reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the Commissioner of workers' compensation in accordance with Insurance Code §1305.101(c). Whether or not a pharmacy benefit management program can be licensed as a certified network in the future is not contingent on HB 473 (80th Legislature); rather, the issue is whether or not the pharmacy benefit management program meets the certification requirements under Chapter 10 rules and TIC Chapter 1305 on January 1, 2011. However, the Division points out that a prescription medication is defined as "health care" under Labor Code §401.01119) and that pharmacists and pharmacies are considered health care providers under Labor Code §401.011(21) and (22). Additionally, if an entity is performing the acts of an informal or voluntary network as defined by Labor Code §413.0115 and Division rule §133.2, then that entity is subject to regulation under the provisions of HB 473 and applicable Division rules.

Section 133.4: A commenter recommends language be added to provide that after receipt of the notice required under subsection (b), a physician or health care provider may object to the addition of an insurance carrier or person's access to a discounted fee, that the health care provider may terminate its contract by providing written notice to the voluntary network not later than the 30th day after receiving the notice, and that an insurance carrier may not access or be entitled to the contracted rate following the physician's objection. The commenter also recommends the notice include the address to which a physician may send his or her objection. The commenter recommends that an informal or voluntary network may not terminate the physician-network contract, modify the contracted rate, or otherwise retaliate against a physician for objecting to the addition of an insurance carrier as a payor under his or her contract.

Agency Response: The Division disagrees. The recommended language is beyond the rulemaking authority of the Division. Labor Code §413.011(d-2) requires the Division to establish the time and manner that an informal network or voluntary network, or the carrier, or the carrier's authorized agent, as appropriate, must notify the health care provider of any person that is given access to the network's fee arrangements with that health care provider. Health care providers are encouraged to review the termination clause provisions in the contracts they sign with informal and voluntary networks to determine the notice provisions, if any, that are required before a health care provider terminates his contract with the informal or voluntary network.

Sections 133.4(b) and (c): A commenter requests that the definition of "person" in proposed §133.4(a) and the notification requirement in proposed §133.4(b) retain a specific reference to situations in which the fee arrangement is leased. The commenter further recommends that proposed §133.4 clearly encapsulates existing situations in which an informal network or voluntary network leases its network to another entity, which then leases it to yet another third entity.

Agency Response: The Division agrees that the definition of "person" in adopted §133.4(b) applies to any time that an informal or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed to another individual or entity on behalf of an insurance carrier. The term "person," however, does not include an injured employee. For this reason, the Division does not agree that further changes to the definition of "person" in new §133.4(b) are necessary, or that changes to the required notice provision in new §133.4(c) are necessary for the purpose of addressing the multiple selling, leasing, transferring, or conveying of such fee agreement. New §133.4(b) and new §133.4(c) specify when a notice to the contracted health care provider is required.

Sections 133.4(b), (c) and (d)(2)(A): A commenter recommends including insurance carriers in the definition of "person" in proposed §133.4(a). The commenter states that it appears the Division intends for carriers to comply with the requirements for a "person" in the rule since proposed §133.4(c)(2)(A) refers to an "...insurance carrier, or other person..." and proposed §133.4(b) refers to "...any person to whom the informal or voluntary network's fee arrangement with that health care provider is sold..." The commenter recommends including the term "carriers" in the definition of person in proposed §133.4(a) and removing other subsection references to "insurance carriers or other persons" since such phrase is not used consistently.

Another commenter states that proposed §133.4(a) defines "person" as "an individual, partnership, corporation or other entity to whom an informal network or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed on behalf of an insurance carrier," excluding an injured worker. The commenter believes this definition limits the term "persons" to customers of the voluntary or informal network whose identities are of significance to providers. The com-

menter states that proposed §133.4(b) directs that the health care provider receive notice of "any person that is given access to the network, including, but not limited to, any person to whom the fee arrangement is sold, leased, transferred or conveyed." The commenter states that since "person" is defined in proposed §133.4(a) to include an entity to whom a voluntary or informal network's fee arrangement is sold, leased, transferred or conveyed, the varying language in proposed §133.4(b) is likely to lead to confusion. The commenter recommends using the defined term "person" in proposed §133.4(b), so that the language would read: "Each informal or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement." The commenter recommends a similar change with respect to proposed §133.4(c)(2)(A) for the same reasons.

Agency Response: The Division agrees that "person" applies to any individual or entity, including, but not limited to, an insurance carrier, to whom an informal or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed on behalf of an insurance carrier. In the event that such fee arrangement is sold, leased, transferred, or conveyed to an insurance carrier, the insurance carrier would satisfy the definition of "person" in adopted §133.4(b). For purposes of clarifying this intent, the Division specifically adds the term "insurance carrier" to the definition of "person" in new §133.4(b). The Division further agrees that since new §133.4(b) defines "person," it is necessary to delete in adopted §133.4(c) the phrase "including, but not limited to, any person to whom the informal or voluntary network's fee arrangement with that health care provider is sold, leased, transferred, or conveyed" in an effort to avoid confusion about the meaning of "person" as it relates to when notification is required. For the same reason, it is necessary to delete in adopted §133.4(d)(2)(A), the phrases "insurance carrier, or other" and "including, but not limited to, any person to whom the informal or voluntary network's fee arrangement with the health care provider is sold, leased, transferred, or conveyed." These changes avoid possible inconsistencies in the meaning of "person."

Section 133.4(c): A commenter states that proposed §133.4 does not specify whether the informal or voluntary network, or the insurance carrier, has the duty to notify the affected health care provider. The commenter also suggests that both informal/voluntary networks and insurance carriers have a duty to notify a physician of the intent to alienate or access a contract rate arrangement. The commenter recommends the rule require the informal or voluntary networks to provide the notification but allow an informal or voluntary network to delegate the function of notification, yet retain the ultimate responsibility for all delegated functions and be directly accountable for compliance. A commenter recommends the rule require the insurance carrier or insurance carrier's agent to provide the notification but allow the carrier or the insurance carrier's agent to delegate the function of notification, yet retain the ultimate responsibility for all delegated functions and be directly accountable for compliance. For both recommendations, the delegation must be evidenced in writing; retained by the informal or voluntary network for a period of 6 years from the anniversary of the termination of the delegation agreement; and made available on request of the Division. A commenter recommends an insurance carrier or the insurance carrier's agent, as soon as practicable, should be required to notify each physician upon obtaining the right or authorization to access a contracted rate of the physician.

Agency Response: The Division disagrees. Labor Code §413.011(d-2) does not specify which entity has the responsibility to notify a health care provider of any person that is given access to the network's fee arrangements with that health care provider. If a carrier or the carrier's authorized agent chooses to use an informal or voluntary network, Labor Code §413.011(d-2) would require an informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, to notify each health care provider of any person that is given access to the fee arrangement. To remain consistent with the provisions of Labor Code §413.011(d-2), new §133.4 allows the insurance carrier, the insurance carrier's authorized agent, or the informal or voluntary network, the flexibility to determine which entity will provide the notice to affected health care providers. In addition, new §133.4(i) provides that the insurance carrier may be held liable for administrative violations in accordance with applicable Labor Code provisions and Division rules if there is non-compliance with the required notice. Additionally, the Division disagrees with the recommendation that the notice be provided to affected health care providers "as soon as practicable." Labor Code §413.011(d-2) requires the Division to adopt rules regarding the time and manner by which these notices are sent to health care providers. As a result, the Division adopts new §133.4 to provide guidance regarding the time and manner for these notices.

Sections 133.4(c) - (f): A commenter states that proposed §133.4 creates reasonable parameters for the notification requirements. The commenter believes that the information required in the written notifications and the time frames for notification will improve the present situation for system participants. The commenter states that the time frames in proposed §133.4(f) are appropriately tailored and reasonable for informal and voluntary networks.

Agency Response: The Division agrees. Adopted §133.4 will provide increased transparency of a person's access to a health care provider's contractual fee arrangement with an informal or voluntary network as required by Labor Code §413.011(d-2).

Sections 133.4(c) - (f): A commenter recommends that the required notice must notify each affected health care provider via certified mail of any person that is given or sold access to the network's fee arrangement with that health care provider within the time and manner provided by the rule, that the notice must be sent certified mail every 45 days, and include a separate prominent section that lists the insurance carriers that the informal or voluntary network knows will have access the network's fee arrangement. The commenter further recommends that the sender of the notice maintain documentation of the delivery and the date(s) of the certified mail delivery.

Agency Response: The Division disagrees that notice may only be provided by certified mail. Notice by certified mail is not prohibited by adopted §133.4. However, due to the potential volume of notices that may become necessary pursuant to new §133.4, an administrative rule that would restrict notice to certified mail would result in substantial costs to the entity providing notice to the affected health care providers. Instead, new §133.4 allows the insurance carrier, the insurance carrier's authorized agent, or the informal or voluntary network, the flexibility to deliver and document the notice using whatever method best fits its business needs so long as the notice contains the requisite information, is delivered in accordance with the stated timeframes, and can

be reproduced at the request of the Division. Also, §133.4(d) provides that notice to each affected health care provider must include the contact information of any person that is given access to the informal or voluntary network's fee arrangement.

Regarding the recommendation to require that the sender of the notice maintain documentation of the delivery of the notice, the Division points out that new §133.4(e) provides guidance regarding health care provider notice documentation requirements. Specifically, §133.4(e) states that the "the informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall document the information provided in the notice as required by subsection (d), the method of delivery, to whom the notice was delivered, and the date of delivery. For the purpose of this section, a notice is determined to be delivered in accordance with §102.4(p), relating to General Rules for Non-Commission Communication. Failure to provide documentation upon the request of the Division or failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable presumption in a Division enforcement action and in a medical fee dispute that the health care provider did not receive the notification."

Section 133.4(d): A commenter recommends rule language to require the notice include a separate prominent section that delineates any reimbursement policies, such as maximum frequency per day limitations, which may affect the contracted rate of the physician.

Agency Response. The Division disagrees with the recommendation to require reimbursement policies within the notice. Division points out that all health care provided in the Texas workers' compensation system is subject to the billing requirements under the Labor Code and Division rules. Additionally, non-network or out-of-network health care, whether paid as part of an informal or voluntary network contractual arrangement or not, is subject to the Division's treatment guidelines, preauthorization requirements and medical dispute resolution requirements as set out in the Labor Code and Division rules. Informal or voluntary networks are not authorized to vary from the billing or reimbursement requirements under the Labor code and Division rules, with the exception of negotiating a fee amount with the health care provider that varies from the Division's fee guidelines for that same health care service.

Section 133.4(d)(4)(B): Some commenters state that the proposed rule recognizes that the list of health care providers and workers' compensation carriers covered by an informal or voluntary network is likely to change frequently as parties are added to or removed from contractual agreements. Proposed subsection (d)(2) recognizes the need to periodically update the information available to health care providers while proposed subsection (d)(3) unrealistically suggests that the information on the website must always be "current and correct..." In order to avoid the potential conflict in wording, some commenters recommend deleting proposed subsection (d)(3) and replacing proposed subsection (d)(2) with new language to read, "is updated at least monthly with current and correct information."

Another commenter states that the original proposal appears to require the webpage to be updated at least monthly, even if nothing changes. The commenter recommends deleting proposed §133.4(d)(2) and (3) and replacing those proposed subsections with the following language so that the information is current and correct, but would not require the information to be updated every single time there is a change: "(2) contains current and correct information, but is not required to be updated more frequently than monthly."

Agency Response: The Division clarifies that a person to whom an informal network or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed on behalf of an insurance carrier may provide notice to each contracted health care provider through a website link only if the website link contains the information required by adopted §133.4(d)(4). New §133.4(d)(4)(A) and (B) provide that notice to each contracted health care provider may be provided through a website link only if the website link contains the information stated in subsection (d)(1), (d)(2)(A) and (d)(2)(B) and is updated at least monthly with current and correct information. This change clarifies that, at the very least, a monthly update of the webpage with current and correct information is expected.

Sections 133.4(d) and (f): A commenter recommends that the required notice should include the contact information and identification of any insurance carrier, or other person, that has access to the contracted fee arrangement, as well as the contracted range of dates during which the insurance carrier, or other person, has been granted access to the contracted fee arrangement; posting of a list on a secure internet website that includes a separate prominent section that lists the payors that the voluntary network knows will have access to a discounted fee of the physician or health care provider in the succeeding 45-day period. Commenter further recommends that notice must be made within five business days of providing another insurance carrier or person access to the network's fee arrangement.

Agency Response: The Division disagrees that the recommended change in the rule language is necessary. Section 133.4(d) provides that notice to each affected health care provider must include the contact information of any person that is given access to the informal or voluntary network's fee arrangement with a health care provider and the dates during which the person may access a contracted rate. The definition of "person" in new §133.4(b) includes individuals, entities, and also insurance carriers. The term "person" does not apply to an injured employee.

In addition, adopted §133.4(f)(1) and (2) provide the time frames in which the notice must be provided to the affected healthcare providers. New §133.4(f)(1) states that for contracts with health care providers in effect on August 1, 2008, initial notification must be made no later than November 1, 2008, and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis. New §133.4(f)(2) states that for contracts with health care providers entered into after August 1, 2008, initial notification must be made no later than the 30th day after the effective date of the contract and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis. New §133.4(f) provides sufficient time for the health care provider to receive the initial and subsequent notices while providing the sender with sufficient time to deliver the notices. For this reason, health care providers can be assured that they are constantly receiving information about which insurance carriers have access to their contractual fee arrangements and the senders of the notices can adequately administer the notice delivery process with multiple health care providers.

Entities that provide notice through a website link may do so pursuant to §133.4(d)(4) only if the website contains the information stated in subsection (d)(1), (d)(2)(A) and (d)(2)(B) of this section,

and is updated at least monthly with current and correct information.

Section 133.4(e): A commenter states that the informal or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, should maintain and be prepared to present to the Division a record of compliance with the notice requirement. The commenter states it is often difficult to pinpoint the actual delivery date, depending on the method of notice, and, therefore, recommends changing each instance of the term "delivered" in proposed §133.4(e) to "dispatched," as the dispatch of the notice is broad enough to include all permissible methods of notice, and is within the control and knowledge of the informal or voluntary network, insurance carrier, or authorized agent.

The commenter further states that the proposed rule does not impose any obligation on the health care provider to ensure that the contact information he or she has provided to the informal or voluntary network, insurance carrier, or authorized agent is correct for purposes of receipt of the notice. The commenter explains that the absence of such a provision may both undermine the value of the rule's notice mechanism and subject the informal or voluntary network, insurance carrier, or authorized agent to a penalty for deliveries that fail for reasons outside of its control. The commenter recommends a provision that would require the health care provider to keep the informal or voluntary network, insurance carrier, or authorized agent, as appropriate, apprised of its current contact information; or, alternatively, a provision that would relieve the informal or voluntary network, insurance carrier, or authorized agent from a penalty in the event the notice was dispatched but not received due to a health care provider's failure to provide current contact information.

Agency Response: The Division agrees that the method of delivery will assist in determining the date of receipt of the notice by the affected health care provider. The Division has added language to clarify that the sender of the notice is required to document the method of delivery and has deleted the "delivery of the notice" language in subsection (e). The Division further added language stating that "[f]or the purpose of this section, a notice is determined to be delivered in accordance with §102.4(p)." In response to a written comment that it is often difficult to pinpoint the actual delivery date, these changes from proposal are necessary in order for the sender to document the manner in which he provided notice to an affected health care provider and the date of delivery. To determine the date that a notice is delivered to an affected health care provider, the sender should refer to the existing Division rule §102.4(p) in order to establish the date of receipt, which, under the provisions of this section, is based on the method of delivering the notice.

The Division does not agree that it is necessary to require, through the rulemaking process, that the health care provider ensure that the contact information he or she has provided to the informal or voluntary network, insurance carrier, or authorized agent is correct for purposes of receipt of the notice. The Division expects informal and voluntary networks to address issues relating to maintaining accurate contact information for its contracted health care providers through the description of each party's duties in the contract itself. In addition, Labor Code §413.011(d-2) does not impose such rulemaking responsibility on the Commissioner. Instead, Labor Code §413.011(d-2) requires a Commissioner rule to implement the time and manner by which an informal or voluntary network, or the insurance carrier or the insurance carrier's authorized agent, as appropriate, shall notify each health care provider of any person that is given access to the informal or voluntary network's fee arrangements with that health care provider.

Sections 133.4(e) - (f): A commenter states that even though the Division has taken the cost of electronic and paper notifications to health care providers into consideration, it has not considered the cost of manpower and hours it takes to print letters, labels, envelopes, and then stuff them all to mail. The commenter states that it will be time consuming for the personnel required to notify the health care providers and time consuming for the mail room personnel responsible for stamping. The commenter states that copies of the notification have to be filed into the provider files which will also be time consuming. The commenter questions the necessity of placing a copy of the notification in an entity's file for the provider if the entity has documentation that it sent the required notification. The commenter states that it is too costly and time consuming to notify health care providers on a quarterly basis if nothing has changed since the first notification. The commenter recommends sending subsequent notifications only when there is a change that makes it necessary to inform the health care provider(s). Agency Response: The Division points out that the requirement for the insurance carrier, carrier's authorized agent or informal or voluntary network to provide a notice to health care providers is a statutory requirement enacted by HB 473 during the 80th Legislature. In an effort to reduce costs for those entities charged with providing the required notice, the Division has given the insurance carrier, the insurance carrier's authorized agent, and the informal and voluntary network, the flexibility to determine which entity will provide the notice to affected health care providers, as well as the flexibility to deliver and document the health care provider notice using whatever method best fits its business needs, so long as the notice contains the required information, is delivered in accordance with the timeframes stated in adopted §133.4(f), and can be reproduced at the request of the Division. Administrative costs are varied and dependent on the notifying entity's business model, its use of technology and automation, and employee pay-scale. Each notifying entity's business model will determine the costs for that entity's business procedures since the use of automation and manual labor will vary for each entity. Additionally, new §133.4 does not dictate the method that an informal or voluntary network should use to maintain documentation that notice was delivered. Rather, new §133.4 simply specifies what information needs to be documented and available at the request of the Division. Finally, the commenter states that quarterly notices are too costly and time consuming and that notice should only be provided when there is a change that needs to be communicated to health care providers. The Division appreciates the comment, but disagrees that a quarterly notice is too costly or time consuming given that the sender has flexibility to choose the method of delivery. The Division considered requiring a quarterly notice only when changes occur, but determined that requiring a quarterly notice to all contracted providers would be easier for the sender to administer for compliance purposes than requiring a sender to send out individual notices to health care providers at certain time periods when individual changes occur. For these reasons, the Division disagrees that a change to adopted §133.4(f) pertaining to the time of notification is necessary.

Section 133.4(f)(1): A commenter questions whether the Division foresees a change to the deadline date of September 1, 2008, for notifying affected health care providers with voluntary or informal network contracts in effect on June 1, 2008, of the payors that can access their fee schedules.

Agency Response: The Division clarifies that changes from proposal were made in subsection (f)(1) due to the later than anticipated date of the section's adoption. The Division has deleted the terms "June" and "September" and replaced them with "August" and "November" in subsection (f)(1). As explained in the proposal for subsection (f)(1), a period of ninety days should provide the informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent with sufficient time to determine which entity will provide the initial notification for contracts in effect on August 1, 2008.

Section 133.4(g): Some commenters state that insurance carriers are entitled to pay a health care provider "at a contracted fee" if the fee was negotiated by a certified workers' compensation health care network contractual agreement. Another commenter states its understanding that proposed §133.4(g) only applies to "contracted fees" that were negotiated by an informal or voluntary network. Some commenters believe this proposed subsection could mistakenly be interpreted to apply to payments made under a certified health care network. Some commenters recommend the following new language to clarify that this proposed subsection does not apply to certified networks: "The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal or voluntary network if:..."

Agency Response: The Division agrees that adopted §133.4 applies to informal network and voluntary network fee arrangements with a health care provider and not contracts between certified health care networks and health care providers. The Division has adopted new §133.4(a) to state that this section applies to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider in accordance with Labor Code §413.011 and §413.0115. The Division further agrees that it is necessary to change the language of adopted §133.4(g) to clarify that adopted §133.4 does not apply to certified health care networks as follows: "The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:.."

Sections 133.4(g) and (h): A commenter recommends that insurance carriers be required to pay fees in accordance with the Division's fee guidelines if notification to the health care provider does not meet the requirements of subsections (a) - (d). The commenter also recommends language be added to new §133.4(g) which states that a carrier is not entitled to access a contracted rate for services provided prior to, the later of, the dates disclosed in subsection (b), or the date the notice under subsection (c) is sent plus seven calendar days.

Agency Response: The Division disagrees that the recommended language is necessary. Adopted §133.4(g) clarifies the instances in which an insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network. Additionally, adopted §133.4(h) states that Division fee guidelines will apply if the provisions of §133.4(g) are not met, or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable pursuant to §134.1(e)(3), relating to Medical Reimbursement.

Section 133.4(h): A commenter states that the Division's fee guidelines do not provide a payment amount for every procedure that may be performed by a health care provider. The commenter gives the example of the fee guidelines providing for the use of unlisted procedure codes for which there is not a specific rate of reimbursement established in the fee guidelines. As such, the commenter recommends the following language for proposed subsection (h):

"(h) Application of Division Fee Guidelines. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply. In the event the Division fee guidelines do not specify a reimbursement for a procedure or the procedure is appropriately billed under an unlisted procedure code, reimbursement will be based on fair and reasonable reimbursement as defined in §134.1(d)."

Another commenter recommends adding the following sentence to proposed subsection (h) in order to give the parties guidance on the standards for reimbursement in the absence of an applicable Division fee guideline. "If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section, and as provided in Labor Code §413.011(d-1), reimbursement will be based on fair and reasonable reimbursement as defined in §134.1(d)."

Another commenter requests retention of proposed §133.4(h) for application of the fee schedule amount when the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in proposed subsection (g) of this section and as provided in Labor Code §413.011(d-1).

Agency Response: The Division agrees to provide a clarification. The Division has added language to adopted §133.4(h) to clarify that in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3).

Section 133.4(i): A commenter requests retaining proposed §133.4(i) to allow for the assessment of administrative penalties against informal and voluntary networks that take discounts without having complied with statutory and administrative requirements.

Agency Response: The Division appreciates the comment. New §133.4(i) clarifies that an insurance carrier may be held liable for administrative violations that result from noncompliance with Labor Code provisions and Division rules.

Section 133.4(i): A commenter states opposition to this proposed subsection by stating it is beyond the rule making authority of the Division. Some commenters state that there is no legislative authority in HB 473 or Labor Code Chapter 415 in which the Texas Legislature gave the Division expressed or implied authority to hold an insurance carrier responsible for administrative violations committed by an informal network, voluntary network, or any other legislatively recognized stakeholder. Some commenters believe the only penalty identified in HB 473 for the failure to give proper notice to the health care provider under §413.011(d-2) is the obligation to reimburse the provider in accordance with the Division fee guidelines as stated in §413.011(d-3)(3)(B). The commenter states that imposing additional penalties against the insurance carrier would be wrong and biased against the insurance carrier, especially if the notification violation was committed by another stakeholder. Another commenter recommends changing this subsection to hold the entity responsible for delivering the notice liable for administrative violations, rather than the insurance carrier.

A commenter recommends the following new language for proposed §133.4(i): "(i) Administrative Violations. If notification to the health care provider does not meet the requirements of sub-

sections (b) - (e) of this section, the insurance carrier may be held liable for any administrative violations if the contract between the insurance carrier and the informal or voluntary network specifies that it is the responsibility of the insurance carrier to notify health care providers in the manner required by subsections (b) - (e) of this section. In the event the contract between the insurance carrier and informal or voluntary network specifies that it is the responsibility of the informal or voluntary network to notify health care providers in the manner set forth in subsections (b) - (e) of this section, the informal or voluntary network may be held liable for any administrative violations."

A commenter states that with the passage of HB 473, the TDI now has regulatory authority over informal and voluntary networks. The commenter states that if an informal or voluntary network fails to comply with the notification requirements of this section and is responsible for notifying health care providers under the terms of the contract that has been entered into by the informal or voluntary network and the insurance carrier, the informal or voluntary network should be held liable for any administrative violations of the rules.

A commenter notes that the Division has acknowledged in proposed §133.5(e) that the Texas Department of Insurance has regulatory authority over informal and voluntary networks that includes imposing penalties when the statute or a rule is not complied with by the informal or voluntary network. Proposed §133.5(e) provides that the Division may penalize an informal or voluntary network that fails to report data required by § 413.0115 of the Texas Labor Code and proposed §133.5.

Agency Response: The Division disagrees with the recommendation to delete language in new §133.4(i) that makes the insurance carrier potentially liable for administrative violations resulting from noncompliance with new §133.4. The Division also disagrees with the recommendation to change new §133.4(i) to clarify that the entity responsible for delivering the notice is liable for any administrative violations imposed by the Division. Although Labor Code §413.011(d-1) and (d-2) allow the insurance carrier, the carrier's authorized agent or the informal or voluntary network to deliver the health care provider notice under this section, Labor Code §413.015 requires insurance carriers to make appropriate payment for health care in accordance with the agency's medical policies and fee guidelines and Labor Code §413.016 authorizes the Division to investigate and take enforcement action against an insurance carrier that pays for health care inconsistent with the agency's medical policies or fee guidelines.

In accordance with Labor Code §413.011(d-1) insurance carriers are allowed to pay a fee to health care providers that is inconsistent with the agency's fee guidelines if certain requirements are met. If a carrier chooses to use an informal or voluntary network to contract with health care providers for fees that are inconsistent with the agency's fee guidelines, Labor Code §413.011(d-1)(1) and (2) state that 1) there must be a contract between the insurance carrier or its authorized agent and the informal or voluntary network that authorizes the informal or voluntary network to contract with health care providers on its behalf; and 2) the contractual arrangement between the informal or voluntary network and the health care provider include a specific fee schedule and complies with the health care provider notice requirements laid out in Labor Code §413.011(d-2) and Division rules. The Division's interpretation of the statutory language under Labor Code §413.011, §413.015 and §413.016 is that the insurance carrier is ultimately responsible for ensuring that the proper payment is made for health care services in the Texas workers' compensation system and an informal or voluntary network is acting on behalf of the insurance carrier to obtain contractual fee arrangements with health care providers that are inconsistent with the agency's fee guidelines. HB 473 authorized the continued use of contractual fee arrangements outside of certified workers' compensation health care networks until January 1, 2011, but placed certain requirements, including the health care provider notice requirement in place in order for those contractual fee arrangements to be valid. As such, the Division has determined that the insurance carrier cannot ensure that proper payment is made to health care providers under the Act and applicable Division rules without ensuring that all of the requirements which authorize the ability to pay a fee inconsistent with the agency's fee guidelines, namely the notice provision under Labor Code §413.011, are also met.

Additionally, Labor Code §413.0115(c) and new §133.5 specifically require the informal network or voluntary network to report certain information to the Division. New §133.5(e) acknowledges this statutory responsibility imposed on the informal or voluntary network and accordingly provides that failure to report the specified data may result in an administrative violation.

Section 133.4(i). A commenter recommends new language providing that this section subjects an entity to an administrative penalty of $10,000.

Agency Response: The Division disagrees. The Division has added language to §133.4(i) to clarify that the insurance carrier may be held liable for administrative violations in accordance with applicable Labor Code provisions and Division rules if there is non-compliance with the notice to the health care provider. Labor Code §415.021 provides that the Commissioner of Workers' Compensation may assess administrative penalties against any person who violates the Labor provisions and Division rules of up to $25,000 per day per occurrence.

Section 133.4(k): A commenter recommends changing proposed §133.4(k) to clarify the expiration date of this section and that this section will apply to unresolved fee disputes over services rendered prior to January 1, 2011:

(k) In accordance with §413.011(d-6), the provisions of this rule shall expire January 1, 2011. Notwithstanding the provisions of this subsection, the provisions of this rule apply to medical services covered by an informal or voluntary network agreement that were rendered on or before December 31, 2010.

Another commenter recommends changing this proposed subsection to state, "In accordance with §413.011(d-6), the provisions of this rule apply to medical services covered by an informal or voluntary network agreement that were rendered on or before December 31, 2010." The commenters believe the proposed wording may create confusion in 2011 as to whether or not there is any rule in place to assist in deciding unresolved fee disputes over services rendered prior to January 1, 2011.

Agency Response: The Division agrees that this section will apply to unresolved fee disputes over health care services rendered between August 1, 2008, and December 31, 2010. The Division has adopted §133.4(a) to state that "this section applies to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider in accordance with Labor Code §413.011 and §413.0115. In addition, the Division has added language to adopted §133.4(k) to clarify that this section will continue to apply to health care services that were rendered between August 1, 2008, and December 31,

2010, pursuant to an informal network or voluntary network fee agreement with a health care provider.

Section 133.5(a)(5): A commenter states that the Division's on-line reporting system only allows the insurance carrier to be linked with one associated entity. The commenter states that an insurance carrier may have more than one entity working on its behalf and, therefore, recommends that the Division consider revising its on-line reporting system to accommodate multiple linked entities.

Agency Response: The Division appreciates the recommendation to revise its on-line reporting system to allow informal and voluntary networks to report multiple insurance carriers, insurance carrier agents, and other entities with whom they are associated. On March 6, 2008, the Division modified the on-line reporting system to allow informal networks and voluntary networks to report multiple relationships.

For, with changes: Concentra, Coventry, Insurance Council of Texas, Texas Mutual Insurance Company, Zenith, and Texas Medical Association.

Neither For Nor Against: RGV Healthcare Systems, Southwest Medical Provider Network, and Rockport Healthcare Group.

The amendments and new sections are adopted under the Labor Code §§413.011, 413.015, 413.0115, 413.016, 408.0223 (repealed), 415.021, 415.023, 402.00111, and 402.061.

Section 413.011 requires the Commissioner by rule to establish the time and manner for an informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, to notify each health care provider of any person that is given access to the network's fee arrangements with the health care provider. Section 413.015 requires the Commissioner by rule to review and audit the payment by insurance carriers of charges for medical services provided under the subtitle to ensure compliance of health care providers and insurance carriers with the medical policies and fee guidelines adopted by the Commissioner. Section 413.0115 requires voluntary networks and informal networks to report specific information to the Division. Section 413.016(a) provides that the Division order a refund of charges paid to a health care provider in excess of those allowed by the medical policies or fee guidelines. Section 413.016(b) provides that if the Division determines that an insurance carrier has paid medical charges that are inconsistent with the medical policies or fee guidelines adopted by the Commissioner, the Division shall investigate the potential violation. Former §408.0223 established the requirements of an insurance carrier network before its repeal by Chapter 265, Acts of the 79th Legislature, Regular Session, 2005, and constitutes the manner by which a voluntary network is defined. Section 415.021 provides that the Commissioner may assess an administrative penalty against a person who commits an administrative violation. Section 415.023 provides for certain administrative violations as a matter of practice. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides the Commissioner with the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§133.2. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Bill review--Review of any aspect of a medical bill, including retrospective review, in accordance with the Labor Code, the Insurance Code, Division or Department rules, and the appropriate fee and treatment guidelines.

(2) Complete medical bill--A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing).

(3) Emergency--Either a medical or mental health emergency as follows:

(A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health or bodily functions in serious jeopardy, or

(ii) serious dysfunction of any body organ or part;

(B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(4) Final action on a medical bill--

(A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or

(B) denying a charge on the medical bill.

(5) Health care provider agent--A person or entity that the health care provider contracts with or utilizes for the purpose of fulfilling the health care provider's obligations for medical bill processing under the Labor Code or Division rules.

(6) Insurance carrier agent--A person or entity that the insurance carrier contracts with or utilizes for the purpose of providing claims services, including fulfilling the insurance carrier's obligations for medical bill processing under the Labor Code, the Insurance Code, Division or Department rules.

(7) Pharmacy processing agent--A person or entity that contracts with a pharmacy in accordance with Labor Code §413.0111, establishing an agent or assignee relationship, to process claims and act on behalf of the pharmacy under the terms and conditions of a contract related to services being billed. Such contracts may permit the agent or assignee to submit billings, request reconsideration, receive reimbursement, and seek medical dispute resolution for the pharmacy services billed.

(8) Retrospective review--The process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

(9) In this chapter, the following terms have the meanings assigned by Labor Code §413.0115:

(A) Voluntary networks; and

(B) Informal networks.

§133.4. Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks.

(a) Applicability. This section applies to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement

with a health care provider in accordance with Labor Code §413.011 and §413.0115.

(b) Person. Under this section "person" is defined as an individual, partnership, corporation, hospital district, insurance carrier, organization, business trust, estate trust, association, limited liability company, limited liability partnership or other entity to whom an informal network or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed on behalf of an insurance carrier. This term does not include an injured employee.

(c) Required Notice. Each informal network or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider within the time and manner provided by this section.

(d) Notice. Notice to each contracted health care provider:

(1) must include the contact information for the informal or voluntary network, including, but not limited to, the name, physical address, and a toll-free telephone number accessible to all contracted health care providers;

(2) must include the following information in the body of the notice:

(A) name, physical address, and telephone number of any person that is given access to the informal or voluntary network's fee arrangement with a health care provider; and

(B) the start date and any end date during which any person has been given access to the health care provider's contracted fee arrangement.

(3) may be provided in an electronic format provided a paper version is available upon request by the Texas Department of Insurance, Division of Workers' Compensation (Division); and

(4) may be provided through a website link only if the website:

(A) contains the information stated in paragraphs (1), (2)(A) and (2)(B) of this subsection; and

(B) is updated at least monthly with current and correct information.

(e) Documentation. The informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall document the information provided in the notice as required by subsection (d) of this section, the method of delivery, to whom the notice was delivered, and the date of delivery. For the purpose of this section, a notice is determined to be delivered in accordance with §102.4(p) of this title (relating to General Rules for Non-Commission Communications). Failure to provide documentation upon the request of the Division or failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable presumption in a Division enforcement action and in a medical fee dispute that the health care provider did not receive the notification.

(f) Time of notification. Under this section:

(1) for contracts with health care providers in effect on August 1, 2008, initial notification must be made no later than November 1, 2008, and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis; and

(2) for contracts with health care providers entered into after August 1, 2008, initial notification must be made no later than the 30th day after the effective date of the contract and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis.

(g) Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:

(1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

(2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115.

(h) Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title.

(i) Administrative Violations. If notice to the health care provider does not meet the requirements of this section, the insurance carrier may be held liable for administrative violations in accordance with Labor Code provisions and Division rules.

(j) Severability Clause. If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

(k) Expiration. In accordance with §413.011(d-6), the provisions of this rule shall expire on January 1, 2011. This section will continue to apply to health care services that were rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider.

§133.5. Informal Network and Voluntary Network Reporting Requirements to the Division.

(a) Reporting Requirement. Each informal network and voluntary network must provide the following information to the Texas Department of Insurance, Division of Workers' Compensation (Division):

(1) the informal network or voluntary network's name and federal employer identification number (FEIN);

(2) an executive contact for official correspondence for the informal network or voluntary network;

(3) a toll-free telephone number by which a health care provider may contact the informal network or voluntary network;

(4) a list of each insurance carrier with whom the informal network or voluntary network contracts, including the insurance carrier's FEIN; and

(5) a list of each entity or insurance carrier agent associated with the informal or voluntary network working on behalf of the insurance carrier, including contact information for each entity.

(b) Reporting Format. Reports, including changes, must be submitted through the Division's on-line reporting system accessible through the Division's website at www.tdi.state.tx.us.

(c) Reporting Timeframe. Each informal network and voluntary network that has a contract with an insurance carrier or an insurance carrier's authorized agent in effect on September 1, 2007, must report to the Division in accordance with this section no later than August 1, 2008. Except as otherwise provided in this subsection, informal

and voluntary networks must report to the Division no later than the 30th day after the effective date of a contract signed with an insurance carrier or an insurance carrier's authorized agent.

(d) Reporting Changes. Each informal and voluntary network shall report any changes to the information provided under subsection (a) of this section to the Division not later than the 30th day after the effective date of the change in accordance with Labor Code §413.0115 and this section.

(e) Administrative Violations. If the informal and voluntary network report does not meet the requirements of Labor Code §413.0115 and this section, the informal or voluntary network may be held liable for any administrative violations.

(f) Expiration. The provisions of this rule shall expire on January 1, 2011.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 7, 2008.

TRD-200803486
Norma Garcia
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: July 27, 2008
Proposal publication date: March 7, 2008
For further information, please call: (512) 804-4716

♦ ♦ ♦

TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 344. LANDSCAPE IRRIGATION

The Texas Commission on Environmental Quality (commission, TCEQ, or agency) adopts the repeal of §§344.1, 344.4, 344.10, 344.49, 344.58 - 344.63, 344.70 - 344.73, 344.75, 344.77, and 344.90 - 344.96; and adopts new §§344.1, 344.20 - 344.24, 344.30 - 344.38, 344.40 - 344.43, 344.50 - 344.52, 344.60 - 344.65, 344.70 - 344.72, and 344.80.

Sections 344.1, 344.24, 344.30, 344.34 - 344.36, 344.38, 344.43, 344.50, 344.51, 344.60 - 344.65, 344.70 - 344.72 and 344.80 are adopted *with changes* to the text and will be republished. Sections 344.20 - 344.23, 344.31 - 344.33, 344.37, 344.40 - 344.42, and 344.52 are adopted *without changes* to the proposed text as published in the February 1, 2008, issue of the *Texas Register* (33 TexReg 899) and will not be republished.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE ADOPTED RULES

The adopted new rules will establish the duties and responsibilities of irrigators, irrigation technicians, and irrigation inspectors; provide clarification for better enforcement; reflect the change in the agency name; update statutory references; and correct grammar and cross-references. The rulemaking implements changes made to Texas Occupations Code, §1903.053 and §1903.251, and the addition of Texas Water Code (TWC), §49.238, and Local Government Code, §401.006, by House Bill (HB) 4, HB 1656, and Senate Bill (SB) 3, 80th Legislature, 2007. This adoption addresses local, state, and national demands for conserving and protecting the state's water resources.

Although technology and conservation methods have evolved over the years, no substantive changes have been incorporated into the existing rules since 1996. The adopted new rules will ensure that the agency's rules are up to date and consistent with statutory standards and help to ensure that the rules are effective. Because of the number of changes made, repealing the existing rules in their entirety and proposing new rules make the changes easier to present and understand. The adopted new rules are reorganized to provide better readability. The adopted new rules will revise existing criteria for the design, installation, service, and operation of irrigation systems to be consistent with best industry practices and technology.

HB 4/SB 3 directed the commission to adopt rules that govern: (1) the connection of an irrigation system to any water supply; (2) the design, installation, and operation of irrigation systems; (3) water conservation; and (4) the duties and responsibilities of irrigators.

HB 1656 adds a new landscape irrigation license classification, "irrigation inspector," and directs municipalities with populations of 20,000 or more to adopt ordinances that require irrigation system irrigators be licensed by the commission and obtain a permit before installing an irrigation system. Municipalities must adopt standards and specifications for designing, installing, and operating irrigation systems and include any rules adopted by the agency that are related to landscape irrigation.

Municipalities may employ or contract with a licensed plumbing inspector or licensed irrigation inspector to enforce the ordinance. Municipalities may collect a fee to recover costs of the program. Municipalities must exempt on-site sewage systems, agricultural irrigation systems, and irrigation systems connected to a well and used by the property owner for domestic use.

HB 1656 allows water districts to adopt rules that meet the same criteria as municipalities, except that districts may employ or contract with a licensed plumbing inspector, a licensed irrigation inspector, the district's operator, or another governmental entity to enforce the rules. Water districts must exempt on-site sewage systems, agricultural irrigation systems, and irrigation systems connected to a well and used by the property owner for domestic use.

As required by HB 4, §19 and SB 3, the commission must adopt standards no later than June 1, 2008, with an effective date of January 1, 2009. Therefore, the adopted effective date of the repeal of the existing Chapter 344 and replacement with new Chapter 344 is January 1, 2009.

The existing Chapter 344 is repealed. A new Chapter 344 is adopted and is consistent with HB 4, SB 3, and HB 1656, compatible with best irrigation practices, and that improves readability.

SECTION BY SECTION DISCUSSION

Subchapter A, Definitions

Adopted new §344.1, Definitions, will define air gap; Atmospheric Vacuum Breaker; backflow prevention; backflow prevention assembly; completion of irrigation system installation; consulting; cross-connection; design; design pressure; Double Check Valve; emission device; employed; head-to-head spacing; health hazard; hydraulics; inspector; installer, irrigation inspector; irrigation plan; irrigation services; irrigation system;

irrigation technician; irrigation zone; irrigator; irrigator-in-charge, landscape irrigation; license; mainline; maintenance checklist; major maintenance, alteration, repair, or service; master valve; matched precipitation rate; new installation; non-health hazard; non-potable water; pass-through contract; potable water; Pressure Vacuum Breaker; reclaimed water; records of landscape irrigation activities; Reduced Pressure Principle Backflow Prevention Assembly; static water pressure; supervision; water conservation; zone flow; and zone valve. Three definitions in the existing section, "Non-toxic Substance," "Precipitation Zones," and "Toxic Substance" are not being adopted in the new section because the terms are not used in this chapter. The definition of "Council" in the existing section is not adopted in the new section. The definition is not necessary, because the use of the term "council" in §344.80 means the Irrigator Advisory Council. The definition for design was changed from sprinkler heads to emission devices. The definition of design pressure was adopted with changes. The definition of irrigator-in-charge was clarified to exempts business owners. The definition for irrigation services added the term "selling." The definitions for landscape irrigation, new installation, pass-through contract, records of landscape irrigation activities and zone flow were adopted with changes. The change to "landscape irrigation" clarified the definition. The change to "new installation" removes the phrase that one or more new zones would require an irrigation plan. The change to "records of landscape irrigation activities" removes some of the items to be kept. The change to "zone flow" includes adding gallons per hour and changes the way the flow is determined.

Subchapter B, Standards of Conduct for Irrigators, Installers, Irrigation Technicians, and Irrigation Inspectors, and Local Requirements

Adopted new Subchapter B will establish certain standards of conduct for licensees and establishes requirements for local regulations and inspections. The new Subchapter B incorporates the existing §§344.90 - 344.92 and part of §344.93.

Adopted new §344.20, Purpose of Standards, establishes the reasons for these standards of conduct. The proposal implements changes made to Texas Occupations Code, §1903.053 and §1903.251 and the addition of TWC, §49.238 and Local Government Code, §401.006, by HB 4, SB 3, and HB 1656, 80th Legislature, 2007. Adopted new §344.20 is similar to and update the previous §344.90 to include irrigation inspectors and irrigation technicians.

Adopted new §344.21, Intent, establishes the intent of these standards. It is necessary to prescribe responsibilities of licensees in accordance with Texas Occupations Code, §1903.053(a)(4). The section is similar to the existing §344.91. Specific references to enforcement activities are added by the adopted rule.

Adopted new §344.22, Proficiency in the Field of Irrigation; Representation of Qualifications, establishes the requirement that irrigators, installers, irrigation technicians, and inspectors exhibit knowledge and proficiency when performing irrigation activities. The adopted §344.22 establishes the requirement that irrigators, installers, irrigation technicians, irrigation inspectors, and business owners accurately and truthfully represent their qualifications. The adopted new rule requires irrigators, installers, irrigation technicians, and inspectors to be knowledgeable of local requirements related to landscape irrigation. The requirements are necessary to help ensure efficient irrigation practices.

Adopted new §344.23, Irrigation Practice, prohibits false, misleading or deceptive practices related to irrigation services. The existing rule, §344.93(c), only applies to false, misleading, or deceptive practices related to bidding or advertising of services and fees by irrigators or installers. The adopted new rule adds selling, installing, maintaining, altering, repairing, servicing or inspection to the prohibition. This new requirement is necessary to help ensure efficient irrigation practices.

Adopted new §344.24, Local Regulation and Inspection, establishes that irrigators, installers, irrigation technicians, and inspectors must comply with local requirements, ordinances, and regulations. The existing rule, §344.70, applies to irrigators and installers. The adopted new rule adds irrigation inspectors and irrigation technicians to the rule. The adopted new rule allows regulatory authorities to inspect irrigation systems connected to their public water systems. The language is similar to existing §344.71, except the existing rule states that it "is not required to be inspected" and the adopted rule states that the system "may" be inspected. The adopted rule requires municipalities with a population of 20,000 or more and water districts that implement irrigation programs to verify that the irrigator that designs and installs an irrigation system holds a valid license and has obtained the necessary permits prior to the installation. These entities may also conduct inspections to verify that the design and installation meet the requirements contained in this chapter or the local ordinance or rules, if more stringent. The adopted rule requires each inspector to maintain a log of inspections for three years. The adopted rule exempts from the inspection requirements a landscape irrigation system that is part of an on-site sewage disposal system, an agricultural operation or is connected to a well used by the property owner for domestic use. It is necessary to set these standards to better enforce the landscape irrigation rules.

Subchapter C, Requirements for Licensed Irrigators, Installers, Irrigation Technicians, and Irrigation Inspectors

Adopted new Subchapter C establishes the duties and responsibilities of irrigators, installers, irrigation technicians, landscape irrigation business owners, and irrigation inspectors. It is necessary to define the responsibilities of those who engage in landscape irrigation in order to provide a better understanding of these responsibilities and to better enforce the landscape irrigation rules. Adopted new Subchapter C incorporates the existing §§344.4, 344.49, and 344.58.

Adopted new §344.30, License Required, requires irrigators, installers, irrigation technicians, and irrigation inspectors to hold a valid license. The requirement in the existing chapter for installers to work under the supervision of a licensed irrigator when connecting an irrigation system to a water supply continues. The adopted rule establishes an irrigation technician's role on January 1, 2009, to allow the irrigation technician to install, maintain, alter, repair, and service an irrigation system as well as connect an irrigation system to the water supply under the direction of a licensed irrigator. The licensed irrigator is responsible for the work performed by an irrigation technician on a landscape irrigation system. This section also addresses the license requirements for an inspector that may be employed or contracted by a municipality or water district to enforce landscape irrigation ordinances or rules. Adopted new §344.30(c) requires licensed irrigation technicians to be consistent with the licensed irrigation installers. Adopted new §344.30(h) clarifies the requirements that a home or property owner who installs an irrigation system must meet.

Adopted new §344.31, Exemption for Business Owner Who Provides Irrigation Services, establishes the conditions under which a business owner could engage in irrigation activities by employing an irrigator to supervise irrigation activities of the business, as established in Texas Occupations Code, Chapter 1903.

Adopted new §344.32, Responsibilities of a Business Owner Who Provides Irrigation Services places responsibility on the landscape irrigation business owner to ensure landscape irrigation services are supervised by a licensed irrigator serving as the irrigator-in-charge. The business owner is responsible for verifying the validity of the license of any irrigator, installer or irrigation technician working for the business. Because the owner guides the direction of the company, a business owner must ensure irrigation activities are performed in a responsible manner.

Adopted new §344.33, Display of License, makes administrative changes to correct grammar and requires licensees to present their license upon request to any inspector or regulatory authority with authority over landscape irrigation issues in the jurisdiction in which the licensee practices. Additionally, the irrigator, installer, and irrigation technician licensee are accountable to provide proof of licensure when requested by any regulatory authority, irrigation system's owner, or prospective owner. Irrigators, installers, and irrigation technicians are required to display their license at their place of business. The requirement for an irrigation inspector to present the license when requested by a regulatory authority is addressed in this section.

Adopted new §344.34, Use of License, establishes who may use a license and how it may be used. The adopted rule establishes a requirement that an irrigator-in-charge can perform irrigation services at only one entity as an irrigator-in-charge, but may work at other businesses performing irrigation services. The adopted rule includes requirements for the irrigation inspector's use of the license the inspector obtains from the TCEQ. The adopted section was changed to enhance enforceability by replacing the word "may" with "shall" in two places.

Adopted new §344.35, Duties and Responsibilities of Irrigators, establishes that an irrigator is responsible for all permits, contracts, agreements, advertising or other irrigation activity secured and performed using the irrigator's license. The adopted rule requires the irrigator to comply with all of the rules contained in this chapter when performing irrigation work. The adopted rule requires a licensed irrigator to supervise irrigation activities for an unlicensed business owner. It is necessary to set out specific requirements for irrigators doing these irrigation activities because Texas Occupations Code, Chapter 1903, addresses the duties and responsibilities for landscape irrigation activities. This section has been adopted with changes to separate the responsibilities for irrigators that perform only "design" work and those that only "install."

Adopted new §344.36, Duties and Responsibilities of Installers and Irrigation Technicians, establishes the duties and responsibilities of licensed installers and irrigation technicians. The current duties and responsibilities of installers include connecting irrigation systems to water supplies, and installing an approved backflow prevention method as indicated on the site irrigation plan, or according to the licensed irrigator's instructions. The adopted rule allows an irrigation technician, beginning January 1, 2009, to connect, maintain, alter, repair, service, and direct the installation of an irrigation system under the direct supervision of a licensed irrigator. It is necessary to define the duties and responsibilities of irrigation technicians to help ensure the safe and efficient operation of the irrigation system. This section has been adopted with changes to allow an irrigation technician to perform the final walk through or explain the Maintenance checklist to the irrigation system owner or owner's representative.

Adopted new §344.37, Duties and Responsibilities of Irrigation Inspectors, establishes that an irrigation inspector must enforce the rules or ordinances of the employing entity. It is necessary to establish the duties and responsibilities of irrigation inspectors to protect the water supply.

Adopted new §344.38, Irrigator, Installer, and Irrigation Technician Records, establishes the requirement that irrigators, installers, and irrigation technicians make all landscape irrigation designs, invoices, contracts, warranties, or other irrigation business records or documents available upon request to any governing authority within ten business days of a request. This change is necessary to help ensure effective enforcement of and compliance with regulations that relate to landscape irrigation. The section is adopted with changes from the proposed rules, which removes a requirement to keep copies of advertisements and allow ten business days to provide records to the commission or local regulatory authorities.

Subchapter D, Licensed Irrigator Seal

The new subchapter removes the existing requirement for the licensed irrigator to submit a copy of the seal on letterhead or business stationery and to notify the executive director of any changes in the seal or rubber stamp facsimile. The executive director may obtain a copy of the seal or rubber stamp facsimile, if necessary, on a case-by-case basis. A seal is required on the design, irrigation plan and other documents provided to the irrigation system's owner. It is necessary to set requirements for the seal and for use of the seal. The adopted rule incorporates part of existing §344.59.

Adopted new §344.40, Seal Required, requires each licensed irrigator to obtain a seal. The adopted rule prohibits licensed irrigators from engaging in landscape irrigation work until they possess the seal and license. The change is necessary to ensure effective enforcement of and compliance with regulations related to landscape irrigation to protect the water supply.

Adopted new §344.41, Seal Design, prescribes the appearance of a seal. This new section contains requirements identical to those in the existing §344.60, except that the new section explains that the license number on the seal does not need to contain the leading zeros. The adopted rule requires the irrigator to be responsible for the security of the seal. The adopted rule better explains the seal requirements.

Adopted new §344.42, Seal Display, prescribes that the seal or electronic seal and signature be visible and legible on the original document and when the document is copied or reproduced. The adopted rule incorporates parts of §344.60 and addresses new technology. It is necessary to explain the responsibilities of a licensed irrigator in displaying the seal on documents.

Adopted new §344.43, Seal Use, established the required uses of a seal. Grammatical changes were made from the existing rule. The change in structure simplifies the section. The section also required irrigators to sign their legal name and affix their seal on documents presented to irrigation system owners or the owner's representative. The adopted rule requires the irrigator to accept responsibility for documents that have the seal, and for work performed in accordance with the sealed document. The adopted rule ensures that systems are properly installed in accordance with rules and ordinances. The adopted rule requires

irrigators to maintain a copy of all sealed documents for three years. The adopted rule requires that once a seal is utilized on a document, the seal cannot be altered. The adopted rule describes how a seal could be used on a design or specification created by another irrigator. The adopted rule contains a new requirement that the irrigator sign below the seal rather than over the seal. The adopted change makes the irrigator's signature more legible. The adopted rule replaces existing §§344.61 - 344.63. It is necessary to explain the responsibilities of a licensed irrigator in using the seal on documents. The section was adopted with changes to indicate that the presence of the irrigator's seal indicates the acceptance of professional responsibility for the document and references to a "design" were changed to "plan."

Subchapter E, Backflow Prevention and Cross-Connections

Adopted new §344.50, Backflow Prevention Methods, establishes a requirement that all irrigation systems connected to potable water supplies be connected through an approved backflow prevention method. The adopted new section describes the types of backflow prevention methods that are approved, the conditions of use, and installation standards. The change in structure from the existing chapter improves the section's readability and help to ensure the protection of water supplies. This section replaces existing §344.73. The changes provides irrigators, installers and irrigation technicians with a central location to determine which types of backflow prevention assemblies are appropriate for use in specific irrigation applications in Texas.

Adopted new §344.50(a) establishes the requirements for approved backflow prevention methods and their installation. The adopted rule also includes methods to determine which manufacturer's equipment, model, size, and method of installation are approved for use in the United States.

Adopted new §344.50(b) establishes the backflow prevention methods that are to be used in conditions that present a health hazard, and prescribe how the device must be installed. The standards are necessary to help ensure the protection of water supplies.

Adopted new §344.50(c) explains that a backflow prevention device used in a landscape irrigation system designated as a health hazard must be inspected upon installation and annually thereafter. This requirement is in §290.44(h)(4) of this title and is included in this chapter as a convenience. Inclusion of the rule in this chapter better informs irrigators and irrigation system owners of backflow prevention requirements.

Adopted new §344.50(d) establishes when and how a double check valve backflow prevention assembly may be used and would allow the assembly to be used under conditions that do not present a health hazard. It is necessary to provide specific information in the use of a double check valve to help ensure proper use and to protect the water supply.

Adopted new §344.50(e) establishes certain installation requirements when a double check valve is installed below ground. This section was adopted with the change of the location of the y-type strainer to the inlet side. The proposal included a new provision that requires a clearance between any fill material and the bottom and the sides of the double check valve to allow for testing and repair. The proposal required the installation of a y-type strainer on the discharge side of the double check valve. The standards are necessary to help ensure the protection of water supplies.

Adopted new §344.51, Specific Conditions and Cross-Connection Control, replaces existing §344.75, and establishes specific conditions relating to cross connections and prescribes the requirements in different situations. The identification of these conditions is necessary to help ensure the protection of water supplies. Additionally, the title change more accurately reflects the subject matter of the section.

Adopted new §344.51(a) establishes the approved backflow prevention methods when chemicals are added to the water in the irrigation system. This requirement is necessary for the protection of water supplies and for consistency with 30 TAC Chapter 290, Public Drinking Water. In response to comments, an air gap was added as an acceptable backflow prevention method.

Adopted new §344.51(b) requires that a reduced pressure principle backflow prevention assembly device or air gap must be used on each potable water source when a potable and non-potable water source supply water to an irrigation system. This requirement is necessary for the protection of water supplies and for consistency with Chapter 290. In response to comments, the section was changed to allow the use of multiple water sources in an irrigation system.

Adopted new §344.51(c) establishes that irrigation system components utilizing chemical additives must be connected to a potable water system using a reduced pressure principle backflow prevention assembly. This adopted section also clarified how a chemical could be added to an irrigation system.

Adopted new §344.51(d) establishes specific requirements and limitations for irrigation systems that are located on property that is served by an on-site sewage facility. Specific requirements that relate to the design and installation of an irrigation system that is located on property that is served by an on-site sewage facility system are necessary for the preservation of the health and safety of the public. The adopted section changed "on site" to "on-site" for consistency with the remainder of the chapter.

Adopted new §344.52, Installation of Backflow Prevention Device, describes how and when backflow prevention devices should be installed. The requirements help protect the water supply.

Adopted new §344.52(a) requires backflow protection devices be installed on existing irrigation systems that do not have an approved backflow prevention method when certain maintenance, alterations, repairs, or service are made to the irrigation system. These systems could potentially contaminate water supplies and pose a health and safety risk.

Adopted new §344.52(b) prohibits, if used, the installation of a master valve upstream of backflow prevention devices. The installation of an automatic master valve upstream of a backflow prevention assembly could prevent accurate testing of the backflow prevention device, as is required in Chapter 290.

Adopted new §344.52(c) refers to "in service" to be defined as when the irrigation system and backflow prevention device is fully operational after being successfully tested and verified as acceptable for use.

Subchapter F, Standards for Designing, Installing, and Maintaining Landscape Irrigation Systems

Adopted new §344.60, Water Conservation, promotes water conservation practices in the field of irrigation. The adopted requirement adds that systems must also be operated to promote water conservation in addition to those requirements in

the existing §344.72. The operation of irrigation systems affects the water efficiency of a system. The adopted section contains the correct reference to the definition of water conservation.

Adopted new §344.61, Minimum Standards for the Design of the Irrigation Plan, changes the standards for the design of irrigation systems by removing the requirements for wind derating that are currently in existing §344.77(c). The available industry information for wind derating is inadequate. The requirement for minimum standards for precipitation rates currently in existing §344.77(d) was removed because there are more efficient means to achieve water conservation in irrigation systems. Adopted new §344.61 replaces existing §344.77 and adds new requirements. The change in structure from the existing rule is necessary to improve the readability of the section.

Adopted new §344.61(a) requires an irrigator to prepare an irrigation plan for each new installation site. The adopted rule explains how variances from the original plan must be addressed. The adopted rule requires a paper copy of the plan to be on-site at all times during the installation of the irrigation system. The irrigation plan promotes water conservation. The adopted section allows either a paper or electronic copy of the design plan to be on-site. The adopted section requires the location of all controllers, not just automatic.

Adopted new §344.61(b) requires that the irrigation plan for the proposed irrigation system include a statement of the areas covered and not covered by the irrigation system. A proper design must indicate the intended areas of irrigation. The design of an irrigation system is essential to conserve water.

Adopted new §344.61(c) establishes a list of items that are required in an irrigation plan. The adopted rule requires that the design pressure be provided. It is necessary to provide these requirements for designs because adopted new Subchapter F requires that specific design elements be used to conserve water. The adopted section requires that the location and type of controllers (not just automatic) must be included.

Adopted new §344.62, Minimum Design and Installation Requirements, establishes limitations for the use of component parts in a design. Adopted new §344.62(a) replaces existing §344.77 and adopts new requirements. In order to protect the integrity and efficiency of the irrigation system and reduce risks to human health and the environment, the components of an irrigation system should not be used in excess of the limitations that are published by the manufacturer. Irrigation plans should not incorporate design elements that would cause a component to be used in a manner that would exceed the limitations published by the manufacturer.

Adopted new §344.62(b) establishes standards for the spacing of emission devices. The adopted rule does not allow spacing of emission devices further apart than the manufacturer's published specifications. To improve water conservation, the rule adopts a new requirement that does not allow the use of spray or rotary sprinkler heads in areas 48 inches or less and that have impervious surfaces on two or more sides. The rule also adopts a new requirement that irrigation system heads are no closer than four inches to a hardscape, such as a foundation, fence, concrete, asphalt, pavers, or stones set with mortar. The adopted new section replaces existing §344.77(a). It is necessary to establish these standards to promote water conservation. The adopted section changes the prohibition of emission devices in landscapes of four feet and clarifies that the measurement may not include impervious surfaces. The adopted section changes the phrase "sprinkler heads" to "emissions devices" for consistency, and provides an exception for small paved areas such as narrow paved walkways, jogging paths, golf cart paths or other small areas located in cemeteries, parks, golf courses or other public area that have runoff that drains into a landscaped area.

Adopted new §344.62(c) establishes the requirement that the design and installation of an irrigation system's emission components must ensure that they operate within the manufacturer's published operating pressure range. Irrigation plans would be required to use emission devices that would operate at the minimum and not above the maximum sprinkler head pressure published by the manufacturer. The new section replaces existing §344.77(b). This standard is necessary because systems that operate above or below the recommended operating pressure are inefficient and are prone to either waste water or to result in insufficient irrigation.

Adopted new §344.62(d) requires the design and installation of irrigation systems so that water flow in the pipes could not exceed a velocity of five feet per second for polyvinyl chloride (PVC) pipe. The excessive velocity of flow can cause damage to components of the irrigation system, thus wasting water.

Adopted new §344.62(e) establishes a requirement for irrigation systems to have separate irrigation zones based on factors such as microclimate, plant material type, topographic features, soil conditions, and hydrological control. Separate zones promote water conservation.

Adopted new §344.62(f) establishes a requirement for irrigation systems to have matched precipitation rates at all emission devices located in the same zone. Matched precipitation rates promote water conservation.

Adopted new §344.62(g) establishes a requirement that irrigation systems not spray water over impervious surfaces such as concrete, asphalt, brick, wood, stones set with mortar, walls, fences, sidewalks, streets, etc. Limiting the spray of water over impervious surfaces conserves water.

Adopted new §344.62(h) requires the master valve be located on the discharge side of the backflow prevention device, if a master valve is used on a newly installed or on an existing system. The location of the master valve could impact the testing of the backflow prevention device. If included, a master valve would conserve and protect the water supply. The adopted section clarifies that the requirement is "when provided" not "if required" since the use of a master valve is at the discretion of the irrigator.

Adopted new §344.62(i) requires the use of colored PVC pipe primer solvent. Colored PVC pipe primer solvent would promote better adhesion when cementing pipe joints together, thus minimizing leaking pipes, which would promote water conservation. The adopted section states that the primer should be applied in accordance with either the Uniform Plumbing Code or the International Plumbing Code.

Adopted new §344.62(j) establishes the requirement that technology, in the form of rain or moisture sensors, or various other methods, be installed on all new automatic irrigation systems. The requirement could be met by other technologies that are designed to detect moisture and shut off the landscape irrigation system. The requirement extends to new systems and those with automatic controllers that are replaced during a repair. The use of this technology promotes water conservation. The adopted section exempts El Paso, Hudspeth, Culberson,

Jeff Davis, Presidio, Brewster, Terrell, Loving, Winkler, Ward, Reeves, Ector, Crane and Pecos counties from the requirement.

Adopted new §344.62(k) establishes a requirement for an isolation valve on new installations. The isolation valve allows the water flowing to the irrigation system to be manually turned off without turning off the water supply at the water meter, thereby allowing water to be used for other purposes in a building. This would promote water conservation.

Adopted new §344.62(l) establishes that all piping must be covered according to the manufacturer's published specifications. If there are no specifications, a minimum coverage of six inches is established by the adopted rule. A two inch minimum coverage is adopted for areas that have utilities or structures that prevent the minimum recommended coverage. The existing rule provided for a variance where utilities, tree roots, or man made structures are encountered. "Structures" in the previous rule has been changed to "man-made structures" for better understanding. A new requirement will require irrigators to use select fill, to compact all trenches and holes created during the installation of irrigation systems, and return the area to the original grade. The new section replaces existing §344.77(e). Pipes that are not properly covered can be damaged more easily and result in wasted water. The adopted section allows mounding over pipe in certain instances and requires the mounding to be noted on the plan and discussed with the irrigation system owner or owner's representative to address any safety issues.

Adopted new §344.62(m) establishes standards for the use of electrical wiring and wire splices in an irrigation system, including the minimum depth of cover for wiring. The depth of cover for wiring is necessary in order to conform to the National Electrical Code. The code is not a national law, but its observance is mandated in many states and local areas and represents best practices. The new section replaces §344.77(f). The adopted rule requires electrical wiring that is used to connect the automatic controller to any electrical component to be buried at least six inches deep. Use of approved electrical wiring and proper installation is critical to preventing a health hazard. The adopted section states that electrical wire splices which "may be" exposed rather than "are" exposed must be waterproof.

Adopted new §344.62(n) establishes that water within an irrigation system is non-potable. The rule further establishes that no drinking or domestic water outlets, such as hoses used to fill swimming pools or decorative fountains could be connected to an irrigation system. The rule also establishes conditions whereby a hose bib could be attached to the irrigation system. The adopted rule requires the hose bib and any hoses to be labeled, "Nonpotable. Not safe for drinking." The adopted rule helps protect the water supply and public health.

Adopted new §344.62(o) establishes that effective January 1, 2010, an irrigator must be on-site at all times when landscape irrigation activities are being conducted. If the irrigator cannot be on-site, the irrigator is responsible for ensuring a licensed irrigation technician is on-site to supervise the installation of the irrigation system. It is necessary to set out specific requirements for licensed irrigators during irrigation activities to help ensure the safe and efficient service of irrigation systems.

Adopted new §344.63, Completion of Irrigation System Installation, establishes that the irrigator or irrigator technician providing on-site supervision must complete four tasks. The first task requires the irrigator or irrigator technician to conduct a final walk through with the irrigation system's owner or owner's representative to explain the operation of the system. Second, the irrigator or irrigator technician provides a maintenance checklist to the irrigation system's owner or the owner's representative. As part of the checklist, the irrigator provides the manufacturer's manual for the automatic controller, a seasonal watering schedule, a list of parts that require maintenance and a recommended frequency of maintenance and a statement that the system has been installed according to all rules and regulations and has been adjusted for the most efficient application of water. The checklist requires the signature of the irrigator and the irrigation system's owner or owner's representative. Third, the irrigator or irrigator technician must attach a permanent sticker to each automatic controller showing the irrigator's name, license number, company name, telephone number and the dates of the warranty period. Finally, the irrigator or irrigator technician provides a copy of the design plan showing the actual placement of irrigation system components to the irrigation system's owner or owner's representative. The irrigation system owner or owner's representative will be given the original maintenance checklist. It is necessary to set out specific requirements for licensed irrigators during irrigation activities to help ensure the safe and efficient installation of irrigation systems. The adopted section allows the irrigation technician to perform the maintenance checklist duties and apply the sticker to the controller. The adopted section clarifies that if the irrigation system is manual, the sticker is affixed to the original maintenance checklist. The adopted section also clarifies that if an automatic controller is used that the manual should be provided. The adopted section removes the phrase "designed and" from the statement to be sealed in recognition of "design" and "installation" only business and changes "design plan" to "irrigation plan." The adopted section clarifies that the irrigation system's owner or owner's representative should be provided a copy of the plan showing the actual installation of the irrigation system and the maintenance checklist. The adopted section allows current or real time evapotranspiration data to be used in addition to historical evaporation data.

Adopted new §344.64, Maintenance, Alteration, Repair or Service of Irrigation Systems, establishes that the irrigator or business owner is responsible for all work performed during the maintenance, alteration, repair or service of irrigation systems during the warranty period. The irrigator or business owner is not responsible for the professional negligence of another irrigator who works on the same system. The adopted rule requires all trenches and holes created during the maintenance, alteration, repair, or service of an irrigation system be returned to the original grade. The adopted rule requires the use of colored PVC pipe primer solvent on pipes and fittings used in the maintenance, alteration, repair, or service of irrigation systems. The adopted rule requires the installation of an isolation valve when maintenance, alteration, repair, or service of an irrigation system involves excavation work at the water meter or backflow prevention device. It is necessary to set out specific requirements for irrigators during irrigation activities to help ensure the safe and efficient maintenance, alteration, repair, and service of irrigation systems. The adopted section contains language that pipe primer solvent must be installed according to either the Uniform Plumbing Code or the International Plumbing Code. The adopted section clarifies that excavation work at a water meter or backflow device will require an isolation valve on an existing system.

Adopted new §344.65, Reclaimed Water, addresses the use of reclaimed water in landscape irrigation under certain conditions. Having information regarding the use of reclaimed water in land-

scape irrigation promotes water conservation and helps protect the water supply and public health. The adopted section includes the Spanish translation of "Reclaimed Water - Do Not Drink." The adopted section allows the use of reclaimed water in an irrigation system that is connected to the potable water supply. The change is consistent with 30 TAC §290.

Subchapter G, Advertising, Contract, and Warranty

Adopted new §344.70, Advertisement, replaced existing §344.93 and establishes certain requirements for irrigators who choose to advertise in written or electronic media and require that the commission's contact information be prominently displayed at the irrigator's place of irrigation business. It is necessary for all advertisements to include the license number of the irrigator to help ensure that irrigation practices are performed by a person who is qualified to perform them. HB 4/SB 3 directed the commission to adopt rules governing the duties and responsibilities of irrigators. The adopted section clarifies that trailers that advertise irrigation services must display the irrigator's license number.

Adopted new §344.71, Contracts, replaced existing §344.94 and established the information that must be included in estimates, proposals, bids, invoices, and contracts to install landscape irrigation systems. The section requires that documents be written. Certain information must be included in contracts to help ensure compliance with regulations. The adopted new rule requires that the dates that the warranty is valid be provided in the contract. Additionally, §344.71(c) recognizes that pass-through contracts, as defined in §344.1(36), do not require the contractor to hold a license but must identify the irrigator and the license number of the irrigator who is responsible for performing the work and providing a warranty. Definition of this type of contract is required for effective enforcement of this chapter. The adopted section adds in language that the sign in the place of business is for the purpose of addressing complaints and the provision that it was a violation if anyone other than a licensed irrigator or exempt individual received compensation through a pass-through contract was removed. The adopted section was changed to remove the requirement that unlicensed businesses could not receive compensation for pass-through contracts.

Adopted new §344.72, Warranties, replaced the existing §344.96 and establishes the requirement that irrigators provide a written warranty on all new installations. The adopted rule requires that the irrigation system's owner or owner's representative be provided a written document for repair work that includes a breakdown of parts that are expended on the job and do not have to provide a warranty for the materials and labor. If a warranty is provided, the irrigator shall abide by the terms of the warranty. The new section also requires specific information be contained in the written warranty. These requirements are necessary in order to help preserve the water conserving efficiency of irrigation systems and to protect against system failure that could result in wasted water. The adopted section does not require the irrigator's license number on a warranty document. The adopted section removes the requirement to provide the manufacturer's warranties to irrigation system owners.

Subchapter H, Irrigator Advisory Council

Adopted new §344.80, Irrigator Advisory Council, requirements are essentially the same requirements that are in existing §344.10, with changes to grammar to improve readability. The number of meetings that a council member could miss is three consecutive regularly scheduled meetings or more than half of the regularly scheduled meetings in one year. The previous requirement was that a council member could miss half of the regularly scheduled meetings and be removed from the council by the commission. In response to comments, the adopted section was changed to remove the prohibition that council members may not be an officer, employee, or paid consultant of a trade association in the irrigation industry or be related to a person that is an officer, employee, or consultant of a trade association.

FINAL REGULATORY IMPACT ANALYSIS DETERMINATION

The commission reviewed the adopted rulemaking in light of the regulatory analysis requirements of the Administrative Procedure Act, Texas Government Code, §2001.001 *et. seq*., and determined that the rulemaking is not subject to Texas Government Code, §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in Texas Government Code, §2001.0225(g)(3). A "major environmental rule" means a rule, the specific intent of which, is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. The intent of the adopted rules is to address evolving practices and technology in the irrigation industry that relate specifically to water conservation, non-point source water pollution, protection of potable water supplies, responsibilities of licensed landscape irrigators, and enforceability of irrigation rules. These adopted rules also implement HB 4, SB 3, and HB 1656, 80th Legislature, 2007. Although technology and conservation methods have evolved over the years, no substantive changes have been made to these existing rules since 1996. These adopted rules would ensure that the agency's rules are consistent with statutory standards and that they are more reflective of current technical practices and conservation methods. Protection of human health and the environment may be a by-product of the adopted rules, but is not the specific intent of the rules. Therefore, the commission concludes that the adopted rules do not constitute a major environmental rule.

Furthermore, the adopted rules do not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). Texas Government Code, §2001.0225 applies only to a major environmental rule which: (1) exceeds a standard set by federal law, unless the rule is specifically required by state law; (2) exceeds an express requirement of state law, unless the rule is specifically required by federal law; (3) exceeds a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or (4) adopts a rule solely under the general powers of the agency instead of under a specific state law.

The adopted rules do not exceed a federal standard because there are no federal standards regulating the practice of landscape irrigation. The adopted rules do not exceed state law requirements because these rules are required by HB 4, SB 3, and HB 1656. Also, the adopted rules do not exceed a requirement of an agreement because there are no delegation agreements or contracts between the State of Texas and an agency or representative of the federal government to implement a state and federal program regarding landscape irrigation. And finally, these rules are being adopted under specific state laws, in addition to the general powers of the agency.

Therefore, Texas Government Code, §2001.0225 is not applicable to these adopted rules. The commission invited but received no comments on the draft regulatory impact determination.

TAKINGS IMPACT ASSESSMENT

The commission evaluated these adopted rules and performed an analysis of whether these adopted rules constitute a taking under Texas Government Code, Chapter 2007. The specific purpose of the adopted rules is to update the rules to address evolving practices and technology in the irrigation industry, relating specifically to water conservation, non-point source water pollution, protection of potable water supplies, responsibilities of licensed landscape irrigators, and enforceability of irrigation rules. The adopted rules would substantially advance this stated purpose by setting standards for the installation of irrigation systems and by clearly defining the irrigator's, installer's, irrigation technician's, and inspector's responsibilities. The adopted rules implement HB 4, SB 3, and HB 1656, 80th Legislature, 2007.

Promulgation and enforcement of these adopted rules would be neither a statutory nor a constitutional taking of private real property. Specifically, the adopted regulations do not affect a landowner's rights in private real property because the adopted rules would neither burden nor restrict or limit the owner's right to property and reduce its value by 25% or more beyond that which would otherwise exist in the absence of these regulations. In other words, these rules would not constitute a statutory or constitutional taking because they only update existing rules to comply with current technical standards and conservation methods and implement new legislation that does not affect a landowner's rights in private real property.

CONSISTENCY WITH THE COASTAL MANAGEMENT PROGRAM

The commission reviewed the adopted rules and found that they are neither identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(2) or (4), nor would they affect any action/authorization identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(a)(6). Therefore, the adopted rules are not subject to the Texas Coastal Management Program.

PUBLIC COMMENT

The proposal was published in the February 1, 2008, *Texas Register* (33 TexReg 899). The commission held a public hearing on February 26, 2008. The comment period closed on March 3, 2008. The commission received comments from 43 companies and ten trade associations, nine governmental entities, one environmental group and 15 individuals on the rules. Forty-three entities supported the rules, either partially or with changes; 29 entities opposed the rule.

RESPONSE TO COMMENTS

Accord Irrigation Technologies, Accuscapes Landscaping, Bullfrog Irrigation, Chane Irrigation, Creative Scape Design, Green Industry Alliance, Irrigation Services, Lone Star Irrigation, Lower Colorado River Authority, MacAg Technical Services, Nash Irrigation & Landscape, Water Resources Council of North Central Texas Council of Governments representing 26 member communities, Outdoor Concepts, James Stewart Irrigation, RVi, San Antonio Water System, Sierra Club, Software Republic, Turf Pro, Webbers Landscaping/Sprinkler Company, and seven individuals generally supported adoption of the rules.

Christian Irrigation, City of Austin Water Utility, City of San Angelo, Continental Irrigation, City of El Paso, City of San Angelo, Dallas Irrigation Association, Houston Gulf Coast Irrigation Association, Irrigation, Etc., Irrigation Services Unlimited, Lubbock Chamber of Commerce, Moore Sprinkler Company, Inc., Powerspray Landscape & Sprinkler, Texas Turf Irrigation Association, submitting comments from ten local associations, Water Smart Irrigation, Inc., Wilson Irrigation, and three individuals supported portions of the rules and expressed concern over some of the requirements or recommended some changes.

The Irrigation Association (IA) and Rio Grande Valley Irrigation Association provided comments. Ace Sprinkler, City of Lubbock, and City of McKinney requested clarification of the requirements. Cantrell Landscaping & Irrigation advocated increased enforcement against unlicensed individuals.

A Best Lawn Sprinklers, Aquamax Sprinkler Systems, Austin Lawn and Sprinkler Association, Bastrop Gardens, City of Dallas, Degreed Landscaping, Delta Irrigation, Dew Drip Irrigation, Down to Earth, East Texas Irrigation Association, Express Lawn Sprinklers, Farmer's Nursery, Ground Cover, Key Sprinkler, Kirkland Sprinkler, LMS Inc., Lupton Irrigation, Mac's Landscaping and Irrigation, Prince Irrigation, Smart Outdoor Services, Texas Panhandle Irrigation Association, Utz Environmental Services, and Waterspirit, Inc. and two individuals did not support the rules.

The commission appreciates the comments.

The commission's responses to comments received has been organized by subject area. The subjects are: irrigation systems subject to rule; design of irrigation systems; new installations; drawing of actual installation; design standards, supervision; records; water conservation; maintenance checklist; definitions (not covered in other areas); standards of conduct; local regulations; business owners and irrigators-in-charge; irrigators, installers and irrigation technicians; irrigation inspectors; seal; backflow prevention; cross-connections; design and installation requirements; maintenance, alteration, repair or service of an irrigation system; reclaimed water; advertisement, contracts, and warranty; Irrigator Advisory Council; no authority; local authority; Administrative Procedure Act; costs; enforcement; and other comments.

Irrigation Systems Subject to Rule

Several comments were received that suggested some rule components should not apply to all irrigation systems. Comments were received that designs should be optional; be required for commercial projects; that a threshold should trigger drawings; and scaled drawing should be required when the flow rate exceeds 35 to 40 gallons per minute. Some commenters supported drawings for all irrigation systems.

The commission responds that the requirement to prepare and have an irrigation plan on-site during the installation of a new irrigation system has not been changed. The commission responds that HB 4/SB 3 required the adoption of rules that address the design, installation, and operation of irrigation systems, water conservation, and the duties and responsibilities of irrigators. The adopted Chapter 344 rules meet those requirements and will raise the bar for the performance of landscape irrigation services in Texas. The rules mirror some of the IA's April 2005 BMP, that states an irrigation designer or consultant should supply an "Irrigation Design Package" to the irrigation system owner or owner's representative. The package would provide the irrigation system owner or owner's representative with documented irrigation site and zone specific information and values used in design calculations. Providing the owner or owner's represen-

tative a copy of the plan will facilitate future repairs due to wear or breaks as the system ages or for additions or modifications to the landscape or irrigation system. The actual plan will facilitate repairs by allowing owners to replace components with like equipment so that routine maintenance will be accomplished in a manner that will maintain the irrigation system's integrity and will conserve water. The commission did not make changes to §344.61(a) as a result of these comments.

Design of Irrigation Systems

Comments were received on the definition of "design" (§344.1(8)) and the design requirements (§344.61). Some commenters did not think a design should be required. Several commenters supported the design requirements. Several commenters requested clarification of specific requirements.

The commission responds that a design has always been required (See §344.95, Design). The commission was required by HB 4/SB 3 to adopt rules governing the design, installation and operation of irrigation systems. The requirement to produce and provide the irrigation plan to the irrigation system owner or owner's representative is responsive to the legislative mandate to develop rules that address the design of an irrigation system and to address water conservation. A good irrigation design will conserve water by determining the most efficient way to maintain healthy plant life based on factors such as the amount of sun the area receives, the type of soil, wind direction and speed, and any slope in the area being irrigated. Each irrigation system will have a unique combination of features that must be considered to develop a good irrigation system design. Even a large subdivision with hundreds of almost identical homes will have different irrigation requirements - some lots will be corner lots, some yards will have full sun, others will have no sun and the water pressure will be different, thus a design is needed.

The Irrigation Association's (IA) April 2005 Turf and Landscape Irrigation Best Management Practices document (BMP), Appendix B - Irrigation Design Package, states that an irrigation designer or consultant should supply an "Irrigation Design Package" to the irrigation system owner or owner's representative. The purpose of the package is to provide the irrigation system owner or owner's representative with documented irrigation site and zone specific information and values used in design calculations. The IA's Consumer Handbook (Handbook) states that a consumer should expect a scaled drawing as part of any proposal for a landscape irrigation system.

The basic landscape irrigation training course required for licensing in Texas teaches the need to measure the water pressure, calculate the hydraulic losses in the system, and review the watering needs of the landscape prior to installing an addition to the system. The exam that an irrigator must pass to become licensed requires design knowledge. Each irrigator must take continuing education courses to maintain a license; those courses teach design.

The as-built plan would help the homeowner when making future repairs due to wear or breaks as the system ages or for additions or modifications to the irrigation system.

The type of plan to be provided to irrigation system owner is not being mandated. Irrigators may use a computer assisted design program, a blueprint or sketch. It is important that the entries on the drawing are clear and legibly marked. The commission did not make any changes to the rule as a result of these comments.

IA commented that an analysis of system distribution uniformity and overall site water consumption in relation to evapotranspiration data and site specifics could be used to determine water use efficiency rather than a drawing for every irrigation site.

The commission responds that the information suggested by IA is only a part of the factors that should be considered in evaluating an efficient irrigation system. Distribution Uniformity (DU) is a measurement of the distribution of water over a given irrigated area. A perfect DU is 100%. A DU reading of 65% to 75% is considered good. Evapotranspiration is the combination of evaporation and transpiration from plant material. A design will address the types of sensors, controllers, valves and emission devices that will be used, which lead to a more efficient irrigation system. The irrigation plan will indicate the most efficient design considering all site specific information. The commission did not make any changes to the rules based on these comments.

Some commenters suggested removing the requirement to provide the irrigation system owner with the plan showing the actual installation of the irrigation system and some commenters provided alternative recommendations. Some commenters supported a design requirement.

The commission responds that HB 4/SB 3 required the adoption of rules that address the design, installation, and operation of irrigation systems, water conservation, and the duties and responsibilities of irrigators. The adopted Chapter 344 rules meet those requirements and will raise the bar for the performance of landscape irrigation services in Texas. The rules mirror some of the IA's April 2005 BMP, that states an irrigation designer or consultant should supply an "Irrigation Design Package" to the irrigation system owner or owner's representative. The package would provide the irrigation system owner or owner's representative with documented irrigation site and zone specific information and values used in design calculations. Providing the owner or owner's representative a copy of the plan will facilitate future repairs due to wear or breaks as the system ages or for additions or modifications to the landscape or irrigation system. The actual plan will facilitate repairs by allowing owners to replace components with like equipment so that routine maintenance will be accomplished in a manner that will maintain the irrigation system's integrity and will conserve water. The commission did not make any changes to the rules as a result of these comments.

Some commenters stated that homeowners do not have the expertise or knowledge to review the plans, cities do not have the manpower to review the plans and that municipalities should make the decision to require a plan.

The commission responds that HB 4/SB 3 required the commission to adopt rules that address the design and installation of irrigation systems to conserve water. While most consumers probably would not be able to perform pressure system loss calculations or a design pressure calculation, the consumer generally knows where they want the irrigation system installed and what they want to water. The adopted rules do not require municipalities to review the plans. Municipalities with a population of 20,000 or more and water districts that choose to implement a landscape irrigation program are authorized to collect a permitting fee to cover the cost of the program. Local governmental entities may decide the requirements for their permitting program. Drawing a design and performing the supporting calculations were a critical part of the basic irrigation training course and exam. Irrigators must take continuing education courses to maintain their license, numerous courses have been and will be available that address design. An irrigator may contract the

design, or any portion of the design, to another irrigator. The commission did not make any changes to the rules in response to these comments.

There were several comments about the "design" and "irrigation plan" definitions, alternative definitions were provided, clarity requested, and new definitions requested.

The commission responds that the irrigation plan describes the scaled drawing, the scope of the project and the document that represents the changes made in the installation of an irrigation system (an as-built plan or record drawing). The "design" includes all of the elements that are involved in developing the scaled drawing and may include items such as scheduling work. The term "design" was defined in §344.1(8) as the "act" of determining various elements in a landscape irrigation system that would result in an "irrigation plan." "Irrigation plan" was defined in §344.1(19) as "a scaled drawing" that would list "required information, the scope of the project, and represent changes made in the installation". The uses of the terms are consistent in Chapter 344. Information that is necessary to create site specific designs is taught in basic landscape irrigation courses and in continuing education courses that are required to maintain a landscape irrigator license in Texas. The term "scope of work" refers to the boundaries of what the project will accomplish and could include a timeline for accomplishing the project. The irrigator may determine what should be included in the scope of work. The commission agrees that emission devices should be used in the definition (§344.1(8)) of design to be consistent with the remainder of Chapter 344 and §344.43 (e) and (f) was changed to change the word "design" to "plan" to add clarity to the requirement.

New Installations

Numerous comments were received stating that the definition of new installation should not include adding irrigation zones because the current definition would trigger additional requirements and add cost to consumers. Alternative language was suggested that would add new definitions of "modified system and replacement system," "temporary system," and "extension or expansion of an irrigation system."

The commission responds that the definition of new installations has been changed to remove the phrase "or a system where one or more new zone valves are added to an existing system." Since the definition of "new installation" has changed, the permitting requirements would not be triggered by the state's rules. Local areas may have requirements that would require a new permit. The suggested definitions are not needed since the rule changed. Changes were made to §344.1(33) of the rules based on these comments.

Drawing of Actual Installation

Commenters supported and commenters disagreed with the requirement to make changes to the drawing used during construction to show the actual installation of the irrigation system. Several commenters requested clarity in how the requirement could be met and in the terms used in the rule.

The commission responds that the plan can be changed electronically or marked in pen or pencil to replicate the actual installation deviations from the plan. The irrigator or irrigation technician can make the changes as part of the on-site supervision. The plan may be kept electronically or in a binder or protective sleeve to prevent damage from the elements. The irrigation plan should be signed and sealed by the installing irrigator and may be stamped "as built" or "record drawing." A copy of the irrigation plan is provided to the irrigation system owner or operator as part of the final walk through. Since the plan is ultimately provided to the irrigation system owner as part of the final walk through, the signature and stamp are not required. The commission has amended §344.61(a) to allow the use of an electronic plan on-site and has clarified the requirement to provide the irrigation system owner a copy of the final plan in §344.63(4) as a result of these comments.

Several comments were received stating that scaled drawings were not needed, other commenters stated that scaled drawings were needed, other commenters stated that scaled drawings were needed for commercial installations only. Some commenters provided alternative scales. An alternative proposal to use global positioning system (GPS) locations was received. Other commenters requested clarity in how the drawings could be used. One commenter stated that "design pressure" and "scale size" should be included.

The commission responds that HB 4/SB 3 require the commission to adopt and enforce rules related to the design, installation, and operation of an irrigation system and address water conservation. The irrigation plan should include a scaled drawing. A scaled drawing with the minimum essential information as delineated in §344.61 is important for ensuring the installation of the irrigation system is done to the design standards established by the licensed irrigator so that the system performs efficiently and does not waste water. The scaled drawing can be used by other licensed irrigators or the irrigation system owner to make repairs, replace the irrigation system components, or modify the system due to maturing landscape or additions to the irrigation system. The scaled drawings will provide for an objective inspection by landscape irrigation inspectors for purposes of confirming compliance with state and local requirements or water auditors in auditing the system. Use of GPS coordinates for scaled drawings is not practical because the accuracy depends on the quality of the device being used which would require the commission to establish standards the GPS device would have to meet. Use of GPS locations would also be impractical for small sized systems, such as residential, installed to irrigate small areas with multiple zones. The suggestion on the use of flow to represent the irrigation plan can miss some of the critical design and system elements.

The plans, details, and designer intent must be clearly legible. The scale must be set to a standard scale that is indicated on the irrigation plan. The design pressure must also be indicated on the irrigation plan. Changes were made to §344.61(c)(8) and (9) to add the scale and design pressure to the list of items required in the irrigation plan. Changes were made to the rules as a result of these comments.

Several commenters stated that the actual drawing showing the installed irrigation system should be called "as built," "as-built drawings" or "record drawings" and suggested definitions for those terms.

The commission responds that several different terms are used by the industry. The actual drawing showing the installed irrigation system does not endorse any specific term. The commission did not make any changes to the rules as a result of these comments.

Design Standards

Comments were received that information required in the design standards, such as precipitation rates, watering requirements, etc., could not be provided by irrigators and end users could not

use the information unless a special controller was used, so the requirement should be removed.

The commission responds that precipitation rates, plant watering needs, and distribution uniformity are taught in basic irrigation courses and are part of the examination to obtain an irrigator's license in Texas. Continuing education courses used by licensees for obtaining continuing education units for renewing licenses also incorporate these requirements in the training. The information is needed to properly set automatic controllers to deliver a sufficient amount of water to maintain healthy plants without over watering and wasting water. The information can be used by irrigation system owners or their representatives to reprogram automatic controllers. Since some controllers must be reprogrammed after a power outage, the information could be useful to irrigation system owners or operators. The commission did not make any changes to the rules as a result of this comment.

An individual stated that §344.61(c)(6)(A) assumes that all irrigation systems are automatic and suggested rewriting the phrase as "If irrigation system is automatic, then identify and locate controller."

The commission responds that a change to §344.61(c)(6)(A) has been made to reflect "controller" to address both manual and automatic controllers. Changes were made as a result of this comment.

An individual stated that the word "include" in §344.61(b) should be replaced with "identify the total" and replace "complete coverage" with "total coverage" to better identify that an irrigation plan might not cover all areas.

The commission responds that the word "include" has been used in the rules for several years and has a common meaning to irrigators in Texas. The commission did not make any changes to the rules as a result of this comment.

One commenter stated that the irrigation plan referenced in §344.61 should include quantitative information about annual water usage and provided recommended language.

The commission responds that while this is a viable objective, it is beyond the minimum standards these rules are intended to establish. The requirement to include quantitative information may be considered on a local basis or level. The commission did not make any changes to the rules as the result of this comment.

Commenters stated that the requirement that the installed backflow prevention method must be indicated or documented on the site irrigation plan should be removed.

The commission responds that the requirement that the installed backflow prevention method must be included because the owner can verify that the device selected is accepted by the local water purveyor. The backflow device is the single most important device to prevent contamination of the water supply. If the irrigation system owner later decides to inject fertilizer, pesticide or to install a treated component to prevent root growth in the irrigation system, information will be available to determine if a different type of backflow prevention device should be used. The commission did not make any changes to the rules as a result of these comments.

Supervision

Several commenters supported the requirement for on-site supervision. Some commenters stated that the definition of "supervision" should be changed and that a definition for "direct supervision" added. One commenter noted that corresponding changes would be needed in other areas.

The commission responds that there has been a requirement for many years for an irrigator to provide "direct supervision" to a person who assists in the installation, maintenance, alteration, repair, or service of an irrigation system (See Texas Occupations Code, §1903.002(c)(9)). The commission was directed by HB 4/SB 3 to adopt rules related to the duties and responsibilities of landscape irrigators. Beginning January 1, 2010, either the irrigator or the irrigation technician (working under the direction of a licensed irrigator) must be on-site at all times during the installation of an irrigation system. The definition of supervision includes on the job oversight and direction as well as defining direction by an irrigator over an installer and irrigation technician. The commission did not make any changes to the rules as a result of these comments.

Some commenters stated that the "irrigation technician" phrase, license requirements, duties and responsibilities, design and installation requirements should be removed from various sections of the rules. Some commenters stated that the phrase related to the irrigation technician working under the direction of a licensed irrigator beginning January 1, 2010 should be deleted.

The commission responds that the irrigation technician allows the irrigator to spend more time designing, consulting, selling and performing other duties while still providing on-site supervision during the installation of an irrigation system. The licensed irrigation technician will have knowledge about installation of irrigation systems, be able to read and mark-up irrigation plans, inform the irrigation system owner or operator about how the irrigation system works and how to maintain the irrigation system. These are critical tasks in conserving water. The phase-in will allow time for irrigation technicians to become trained and licensed. The commission did not make any changes to the rules as a result of these comments.

Several commenters supported having a licensed person on-site at all times during the installation of an irrigation system. Other commenters did not support having a licensed person on-site during an irrigation system installation. Some commenters disagreed with the cost or timing of the requirement or requested clarity in the requirements. A commenter suggested the requirement apply only during critical steps such as backflow device installation, pipe fitting, valve setting, wiring, and other critical junctures. Another commenter suggested wording similar to the wording used by the Texas Department of Agriculture's pest control operations and certified applicators. Another commenter stated that with numerous electronic devices available, irrigators should be readily available. One commenter stated that if a technician passed a test, he should be allowed to perform work without supervision. Another commenter stated that supervision standards should be relaxed on residential installation. Some commenters stated that the rules were grossly unfair to small and micro businesses. Some commenters suggested an alternative approach of using an apprentice that would be on the job for two years, completed courses, and passed a test to become a technician.

The commission responds that the job site supervision language is critical in the installation of an irrigation system designed to conserve water. The commission was directed by HB 4/SB 3 to adopt rules that address the duties and responsibilities of irrigators, the installation of irrigation systems, and water conservation. A trained, licensed individual can make responsible decisions regarding the installation of the irrigation system, because

even the best design for an irrigation system can be installed in such a way that water would be wasted.

As part of the completion of the irrigation system, the irrigator must sign a statement that the irrigation system was installed in compliance with all state rules and local regulations and provide the irrigation system owner with a copy of the plan showing the actual installation of the irrigation system. The irrigator signing the required statement must have knowledge that the irrigation system will operate correctly to conserve as much water as possible. Having on-site supervision with a trained irrigation technician while the irrigator is away from the site, better assures him the system was installed in compliance with state rules and local regulations.

A phase-in of the requirement to have an irrigator or irrigation technician on-site beginning January 1, 2010 will give the regulated community eighteen months to prepare for the new requirement. The phase-in time should allow sufficient time to recruit, train, test and license irrigators and irrigation technicians to meet the demand for on-site supervision.

The pest applicators license administered by the Texas Department of Agriculture requires successful completion of a test, insurance ($100,000 for property damage and $100,000 for bodily damage), a $180 non-refundable fee, a Nursery License, that the applicant cannot have been convicted of a felony in the last five years, and the employer must submit an application. The commission proposal for an irrigation technician is less expensive and will require less paperwork.

Although electronic devices are available, irrigators or irrigation technicians must be able to evaluate site conditions and determine the impact of changes to the irrigation system that might impact the system's efficiency. An unskilled labor force would not be knowledgeable about how a change (for example using a different size pipe) could impact the performance of the irrigation system. The irrigation technician will not be required to be trained or tested on irrigation system design. Since the technician will not have this knowledge, the irrigator must supervise the irrigation activity.

An irrigator accomplishes work at the site through the people that are hired to perform the actual installation. It is important that irrigators supervise their staff to ensure irrigation systems are installed according to state law and the design and that any deviations from that design will not impact the integrity of the system. The irrigator is ultimately responsible for the irrigation system, so the irrigator must be responsible for the staff that installs the system.

The commenter did not provide any detailed comments or specific information to support the claims that the costs to small and micro-businesses in the fiscal note are incorrect.

The requirement for direct supervision of a person who assists in the installation, maintenance, alteration, repair, or service of an irrigation system has been in Texas Occupations Code, §1903.002(c)(9) for several years. The irrigation technician should assist the small business owner in on-site supervision that would otherwise require a licensed irrigator. The adopted rules will provide greater flexibility for small and micro businesses to comply with the legislative mandate. Since most irrigation businesses are small/micro businesses, they are not at a competitive disadvantage since all irrigation businesses are required to comply with the adopted rules.

The adopted rules require the irrigation technician to complete a training class and pass the examination and then supervise or perform irrigation activities under the direction of a licensed irrigator.

The requirement in §344.30(c) for an irrigation technician to connect an irrigation system to a water supply has been changed. An irrigation technician will be allowed to connect an irrigation system to a water supply without the supervision of an irrigator. This change will make the installer and irrigation technician's duties compatible. Changes were made to the rule as a result of these comments.

A commenter stated that the direct supervision and design requirements cannot be complied with because of a disability. A commenter requested clarity in the on-site requirement.

The commission responds that the enabling legislation for licensing landscape irrigators exempts from the licensing requirement "a person who assists in the installation, maintenance, alteration, repair, or service of an irrigation system under the direct supervision of an individual described by Subchapter F of this chapter who is licensed under Chapter 37, Water Code". The licensed irrigator has been responsible for the "direct supervision" of staff for several years. In fact, allowing a licensed irrigation technician to perform on-site supervision should allow compliance with the legislative mandate more easily since the irrigator does not need to be at the job site at all times but should be available to resolve any problems. As a supervisor, spot checks of work being performed are always appropriate. The requirement for a design has been a critical element in the classroom instruction and examination for licensed irrigators for many years. The design requirements are contained in §344.95 of the existing rules. Numerous continuing education courses cover the principles of irrigation design and continuing education is a requirement for maintaining landscape irrigation license. The change that these adopted rules requires is that the design be memorialized in paper or electronic form. Requiring a paper or electronic drawing of the irrigation system on the job site will allow the irrigation technician to carry out on-site supervision of crews that install the irrigation system. Correctly installing the designed irrigation system will conserve water. HB 4/SB 3 directed the commission to adopt rules that address the design and installation of irrigation systems and the duties and responsibilities of licensed irrigators. HB 4/SB 3 did not provide an exemption for irrigators that might not be able to accomplish the essential duties of design and installation of irrigation systems. However, the TCEQ complies with the Americans With Disabilities Act and does not discriminate on the basis of disability in the administration of its licensing and certification programs. The commission did not make any changes to the rules as a result of this comment.

Records

A commenter stated that the definition of "record of landscape irrigation activities" should not include design notes and irrigation plans. Some commenters stated the records requirements were onerous and burdensome. A commenter stated that there were too many records to retain.

The commission responds that requirement to maintain design notes and advertisements was removed. The irrigation plan is the scaled drawing which illustrates the selected placement of various components that comprise the irrigation system and is important in the repair, maintenance or alteration and maintaining a record of the irrigation system is sufficient. The commission did make changes to §344.1(40) based on this comment.

Some commenters stated that: an irrigator should not be responsible for maintaining records as required in §344.35(d)(5); irrigation system owners should provide information; the commission or any other agency should not be provided any paperwork; that irrigators should determine what records should be retained; or only the permit, warranty and contract should be maintained. IA stated that keeping copies of all records is not practical and that establishing recordkeeping requirements of contractual obligations from a business entity to a consumer was a more practical option.

The commission responds that HB 4/SB 3 directed the commission to adopt rules related to the duties and responsibilities of landscape irrigators. The records that are required in §344.38 do not include the design notes and copies of advertisements. If some parts of the specifications are used consistently, only one copy of the specifications need to be maintained (for example items that refer to the manufacturer's published recommendations). The remaining information is needed in the investigation of complaints. The commission did make changes to §344.38 as a result of these comments to remove the requirement to maintain the design notes and copies of advertisements.

A commenter stated that the agency was concerned about the environment but was creating more paper. Commenters requested clarification of §344.38, asking what was intended in making records available. Commenters supported maintaining records for one year and two years. Commenters supported making records available in: 30, 14, 10, 7 and 5 days. IA commented that two days was not sufficient for small or micro businesses to make records available. A commenter stated that failure to have a plan on-site might need to have a shorter time frame to correct.

The commission responds that a change in §344.38 was made to allow ten business days to provide records to a requesting governmental entity. The records are essential in the conduct of inspections or investigations by irrigation inspectors to ensure the irrigation system in question is compliant with and that the irrigator complied with state laws and local regulations. Irrigators may choose to keep records electronically and make those available to the irrigation system owner or governmental entity or produce hard copies of documents if requested. If an irrigator chooses to keep electronic records, there would not necessarily be more paper used. The rules require the irrigation plan to be on-site during the installation. HB 4/SB 3 require the commission to adopt and enforce landscape irrigation rules related to the design, installation, and operation of irrigation systems, water conservation, and the duties and responsibilities of irrigators. Changes to §344.38 were made as a result of these comments.

Several commenters stated that if an inspector passed an irrigation system there was no reason for the irrigator to keep any records related to the irrigation system. Some commenters did not support requirements for installers and irrigation technicians to maintain records and to make those records available. Some commenters supported the requirement.

The commission responds that HB 4/SB 3 require the commission to adopt and enforce rules related to the design, installation, and operation of irrigation systems, water conservation, and the roles and responsibilities the rule will facilitate the review of complaints to determine compliance with the Chapter 344 rules or local ordinances or rules. It is important to obtain copies of the documents used in the sale, design, installation, maintenance, alteration, repair or service of an irrigation system in order to perform a full investigation of the complaint. An inspector is not required to review or maintain copies of contracts, warranties, or invoices. The commission did not make any changes to the rules as a result of these comments.

An individual asked if plumbers, electricians, landscape architects, or engineers have to keep sealed documents for three years. A commenter stated that no other industry in Texas had to keep these kinds of records.

The commission responds that irrigation system owner places his or her trust in an irrigator to design and install an irrigation system that conserves water. The commission does require maintaining records in other programs. The requirements are related to the duties and responsibilities to conserve a natural resource, water, as outlined in HB 4/SB 3. An irrigation system should work for three years so it is important to maintain records for that period of time. Many parts purchased by professional irrigators have a three-year warranty provided the manufacturer, maintaining records will help irrigation system owners obtain defective parts at no or a reduced cost. The commission did not make any changes to the rules as a result of these comments.

IA commented that regulatory authorities might abuse the requirement to produce records.

The commission responds that the intent of the rule is to facilitate the conduct investigations. Regulatory authorities are held to high ethical standards. Almost every regulatory authority has a complaint and/or whistleblower process that can be used to report suspected abuse. The rule is not intended to allow regulatory authorities to abuse their power in the absence of a complaint. The commission did not make any changes to the rule as a result of this comment.

Water Conservation

Some commenters stated that irrigators should not be responsible for conserving water and that the requirement should be removed and one commenter stated the requirement was too extreme.

The commission responds that HB 4/SB 3 specifically requires the commission to adopt and enforce standards governing water conservation for irrigation system design, installation, and operation. Since landscape irrigation systems use water and irrigators design and install irrigation systems, it is appropriate that water conservation be a responsibility of landscape irrigators. The commission did not make any changes to the rule as a result of these comments.

Several commenters stated that the definition of "water conservation" should be changed and provided alternative language. Several commenters noted that the definition of "water conservation" contained an incorrect reference.

The commission responds that the definition of water conservation was developed to be specific to the Chapter 344 rules so the reference to an irrigation system remains. The definition is needed to add clarity to §344.60, Water Conservation. A mature landscape will not need the water application that a newly installed landscape will need. The commission changed §344.60 to provide the correct reference to the definition of water conservation.

Maintenance Checklist

Some commenters suggested changes to the maintenance checklist definition to only include controller manual, basic scheduling including precipitation rates by station, with a recommended number of minutes to apply one quarter inch of

water per day, the type of plant material being watered, the type of water distribution device being used, the instruction of the operation of the controller and testing the system, and the location of the emergency water shutoff for the irrigation system.

The commission responds that HB 4/SB 3 directed the commission to adopt rules related to the operation of irrigation systems and water conservation. The suggestion to limit the maintenance definition will omit critical items regarding the operation of the system. The adopted definition of maintenance checklist contains information that will help the irrigation system owner maintain and operate the irrigation system in a manner that will promote water conservation. The commission did not make any changes to the rules as a result of these comments.

Several commenters stated that all references to conducting a final walk through of the irrigation system with the owner or owner's representative, completing the Maintenance checklist, placing a sticker on the controller, providing a copy of the design plan to the owner, and that the sticker should be removed. Some commenters recommended changes to the walk through. Other commenters supported the final walk through. One commenter recommended that real time evapotranspiration (ET) data be incorporated into the maintenance checklist.

The commission responds that HB 4/SB 3 directed the commission to adopt rules that address the installation, operation, and water conservation of irrigation systems. The irrigation system's owner or owner's representative must know how to operate and maintain the system to conserve water. The IA's Handbook states that a consumer should expect a full walk through of the irrigation system that will include full instructions on how to care for the system and how to use the mechanical components of the system such as controllers and timers. The items on the maintenance checklist are intended to provide the owner with the necessary information in order to operate the irrigation system in an efficient manner and help conserve water. The sticker on the controller contains contact information for the irrigator and the dates the warranty is valid. The final drawing showing the actual installation of the irrigation system will result in the ability to perform repairs more quickly and will allow the homeowners or irrigator to replace parts with identical parts resulting in water conservation. The drawing facilitates the assessment and changes as the landscape matures and plant watering needs change. Seasonal watering schedules, which irrigators are taught how to calculate in basic irrigation courses and in the continuing education courses, will assist the homeowner in operating an efficient irrigation system. If the owner of the system is aware of the assumptions that were made in designing the system, the owner may be better prepared to reprogram the controller to conserve water and maintain healthy plant material when those assumptions change. The definition of "maintenance checklist" states that the watering schedule is "suggested". The definition of "maintenance checklist" includes "any water conservation measures currently in effect from the water purveyor and the name of the water purveyor". The allowance for real time ET data has been added to the rule in §344.63(2)(B). The commission made changes to the rules as a result of these comments.

IA and other commenters stated that the walk through and checklist requirements were not practical since many irrigation systems were installed at new homes prior to sale to an owner and some projects assign the responsibility for operating the system to the irrigator. Other commenters stated that the checklist requirement eliminates the opportunity for companies to differentiate themselves by offering excellent customer service.

The commission responds that the requirements are more than an opportunity for customer service relationships - they are a cornerstone in making irrigation system owners more aware of the water that is being used in the irrigation system and to provide information on how to reduce the amount of water being used. The sticker on the controller should help the new owner locate the installing irrigator. The package of information (manual, watering schedules, maintenance components, etc.) should be provided to the builder. The builder should, in turn, provide this information to the home owner just as operating information on the dishwasher or stove is provided. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that the wording in §344.62(o) relating to the on-site requirement should be changed to add "final walk through" to the paragraph.

The commission responds that §344.62 refers to the minimum design and installation requirements for an irrigation system. The "walk through" is a part of §344.63 and includes those requirements which are necessary to complete the installation of the irrigation system installation. The commission did not make any changes to the rules as a result of this comment.

Commenters stated that a person or irrigation technician under the supervision of the irrigator-in-charge or an irrigator could complete the checklist and complete the final walk through. A commenter asked if providing a CD to an irrigation system owner covering maintenance of the irrigation system was acceptable.

The commission responds that the rules have been changed to allow an irrigation technician to perform the maintenance checklist items including the final walk through. Providing a CD to a customer that includes information on maintaining the irrigation system is a good tool and could assist the irrigation system owner perform routine maintenance. Changes were made to §344.63 as a result of these comments.

An individual commented that §344.63(2) should be clarified so that it is understood that irrigators should provide a copy of the maintenance checklist to the homeowner.

The commission responds that §344.63(2) has been changed to clarify the maintenance checklist must be provided to the owner, or the owner's representative. Changes were made as a result of this comment.

A commenter stated that the maintenance checklist requirement was cumbersome and caused extra liability to the irrigator.

The commission responds that the checklist will be created with minimal effort and the commission plans to provide a model template. The checklist can be repeated on every job. The information provided on the maintenance checklist will provide owners and operators with information to operate the irrigation system more efficiently, thus conserving water. The rule has been changed in §344.36(d)(2) to allow the irrigation technician to perform the final walk through which should make the process less cumbersome. Changes were made to the rule as a result of this comment.

An individual objected to sealing the maintenance checklist.

The commission responds that sealing the maintenance checklist constitutes the irrigator's acceptance of professional responsibility that the items on the checklist have been completed and provided to the irrigation system's owner or owner's representa-

tive. HB 4/SB 3 directed the commission to adopt rules related to an irrigator's duties and responsibilities. The commission did not make any changes to the rule as a result of this comment.

A commenter suggested that the checklist contain more sophisticated watering schedules.

The commission responds that the proposal has merit and the programming described may be performed by some irrigators as part of the initial controller programming. Local governmental entities may require the scheduling as a method to meet water conservation goals. The commission did not make any changes to the rule as a result of this comment.

A commenter stated that the end user can refuse to sign the maintenance checklist with no consequence and that the irrigation system should be red-tagged until the owner signs the maintenance checklist. A commenter stated that refusal to sign the maintenance checklist sounded confrontational.

The commission responds that the provision was included to allow an irrigator to notate the checklist that the irrigation system owner or owner's representative was unable or unwilling to sign the checklist was intended to prevent confrontation. Every irrigation system owner should want to protect the investment in an irrigation system and have the lowest water bills possible, but there may be occasions when it is impossible to get a signature on the checklist. The rule addresses those occasions. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that not all irrigation systems are automatic and provided alternative language for §344.63(2)(A) and (3). An individual stated that sticker provisions should be made for manual irrigation systems in §344.63.

The commission responds that the suggested change to §344.63(2)(A) states that if the system has an automatic controller, the manufacturer's manual should be provided. To clarify §344.63(3), a change was also made to the rule to clarify placement of the sticker on the automatic controller, and placement of the sticker for a manual controller. The commission changed the rule as a result of the comment.

A commenter stated that §344.63(2)(B), seasonal watering schedule, monthly effective rainfall, plant landscape coefficient factors and site factors should be provided only to irrigation systems installed with an ET or smart controller and provided alternative language. An individual stated that an irrigator would need to understand irrigation auditing to correctly set the watering schedule in the controller.

The commission responds that this information would benefit all irrigation systems and can be used to calculate a watering schedule by hand or by computer. This information is needed so irrigation system owner's can change the watering schedule once plants are established and as seasons change. An irrigator is taught water scheduling in basic training courses that are required to become a licensed irrigator and in subsequent continuing education courses that are required to maintain landscape irrigation licenses. The commission did not make any changes to the rules as a result of this comment.

An individual commented that §344.63 should be changed to ensure that the responsibilities of the irrigator that designs the system and the irrigator that installs the system are clearly defined. An individual commented that he should not be responsible for ascertaining whether changes to designs were made by an installing irrigator and that the irrigator should not be required to collect and maintain as-built for jobs performed by other irrigators.

The commission responds that the language in §344.63(2)(D) has been changed to reflect that the installing irrigator is only responsible for the installation of the irrigation system. Changes to the language on the maintenance checklist should relieve the irrigator designing the irrigation system of any responsibility for as-built plans. Changes were made to the rules as a response to these comments.

Definitions

Some of the comments related to definitions have been addressed in the subject area.

Design pressure. One commenter stated that the sentence "Design pressure is also the manufacturer's published minimum operating pressure" was incorrect.

The commission responds that the definition has been revised to address the comment. Changes were made to §344.1(9) as a result of this comment.

Installer. A comment was made that the word "installer" should be removed from the rules and the only reference should be when the installer license will cease to exist.

The commission responds that the installer will have duties and responsibilities through December 31, 2009. The adopted rules become effective on January 1, 2009. The information is needed during the interim. The commission did not make any changes to the rules as a result of this comment.

Irrigation system. A commenter stated that the definition of "irrigation system" should have the words "and conservation" removed because it might imply that an irrigation system would conserve more water than using other methods to irrigate an area and generally, that is not the case.

The commission responds that although irrigations systems may have different applications, HB 4/SB 3 directed the commission to adopt rules governing landscape irrigation systems that improve water conservation. The purpose of the rules is to improve water conservation in irrigation systems, so the term "and conservation" was not removed from the definition of irrigation system. The commission did not make any changes to the rules as a result of these comments.

Landscape irrigation. A commenter stated that the definition of "landscape irrigation" should be changed to include the phrase "the necessary amount of water to sustain the healthy growth".

The commission concurs with the comment and has changed §344.1(26) to respond to this comment.

Pass-through contract. An individual requested additional clarity and definition of the term.

The commission responds that a pass-through contract is one in which the irrigator or exempt business owner is not a party of the original contract. An example of a pass-through contract would be an owner who contracts with a general contractor to build a shopping center. The general contractor then sub-contracts work to an exempt business owner to install an irrigation system and landscaping. The commission did not make any changes to the rules based on this comment.

Zone Flow. A commenter stated that the definition of zone valve needed to include "gallons per hour" for low volume systems. Some commenters stated that the definition of zone flow would

take four minutes (with an average 16-station test requiring 64 minutes) and would cost the customer $60 to $120 and would waste water. Another commenter stated that the only precise way to determine zone flow is to install a flow meter device or watch the water meter and estimate the zone flow which was only used in water management software. A commenter stated that zone flow would change after more homes are added to the supply line.

The commission responds that the definition has been changed to reflect gallons per hour as an alternative measure for low volume systems and to allow a reading from a flow meter or to let the water meter stabilize after turning on a valve and take a valid reading at that time. The commission made changes to §344.1(45) based on these comments.

Commenters stated that new definitions were needed for "evapotranspiration", "precipitation rate", "dynamic pressure", "pressure regulation", "public water supply", "private potable water supply", and "irrigation efficiency". An individual commented that definition of items called out or detailed was needed but did not provide any additional specificity.

The commission responds that these terms are common terms in the irrigation industry and are taught in basic irrigation training courses and in continuing education courses needed to maintain irrigation licenses in Texas. Additional detail has been added as the result of other comments. The preamble to the rules also provides more detail. Commission landscape irrigation staff or local irrigation programs may be contacted for more specific information. The commission did not make any changes to the rule as a result of the comments.

Standards of Conduct

A commenter stated that the sentence "The legislature has vested the commission with the authority and duty to establish and enforce standards of professional conduct and ethics for practitioners in the irrigation industry." should be deleted. A commenter stated that the requirements of §344.21 are to be used against irrigators and hold irrigators liable for too much.

The commission responds that in the current rules, Chapter 344, Subchapter F contained standards of conduct for licensed irrigators and installers and that the subchapter stated "the legislature has vested the commission the authority and duty to establish and enforce standards of professional conduct and ethics for practitioners of the irrigation industry". The intent of the standards of conduct was to prescribe responsibility and knowledge on the part of the irrigator and installer and to aid in governing the irrigation industry. It is the belief of the commission that the 81st Legislature by passing HB 4, SB 3, and HB 1656 did not provide direction to the commission to change that responsibility. The commission has not made changes based on the comment.

Local Regulations

Numerous commenters stated that exempting irrigation systems that are connected to a groundwater well used by the property owner for domestic use could eventually lead to contamination of a larger water source such as an aquifer. Commenters questioned why the exemption was provided and wanted to know the difference in the contamination of the water supply from the water source. Some commenters stated that an irrigation system connected to a groundwater well should be inspected and have the proper backflow device.

The commission responds that HB 1656 allows irrigation systems that are connected to a groundwater well used by a property owner for domestic use to be exempted from local regulation including permitting, inspection, and enforcement. The commission did not make any changes to the rules based on the comments.

Commenters requested clarification of the inspection requirements, some commenters stated that HB 4, SB 3, and HB 1656 do not require inspections and that water on the discharge side of the backflow device was not required to be inspected by any governmental entity. One commenter supported the inspection requirements as a way to improve irrigation system installations.

The commission responds that HB 1656 requires municipalities with a population of 20,000 or more and allows water districts to adopt and enforce a landscape irrigation program that is at least as stringent as these adopted rules. Other political subdivisions of the state are not prohibited from adopting ordinances or regulations related to landscape irrigation to protect the public water supply. HB 4/SB 3 directed the commission to adopt rules governing irrigation systems and duties and responsibilities of irrigation licensees. The adopted rules establish inspection requirements for inspectors that may be employed or contracted with by the municipalities or water districts. Municipalities and water districts may establish additional inspection requirement for irrigation systems. The commission did not make any changes to the rules as a result of this comment.

Commenters requested clarification of the requirements of §344.30(f) and stated that a plumbing inspector may not be qualified to inspect irrigation systems.

The commission responds that HB 1656 allows municipalities and water districts to employ or contract with plumbing inspectors. HB 1656 did not authorize the commission to require additional training of the plumbing inspectors. While a plumbing inspector may not be knowledgeable of all aspects of irrigation, municipalities and water districts may require additional training to ensure that their employees are knowledgeable about landscape irrigation. The commission did not make any changes to the rules based on these comments.

Some commenters supported allowing cities to adopt more stringent ordinances if needed. An individual stated that all municipalities should implement landscape irrigation programs. An individual questioned whether or not a smaller municipality or other districts could hire an independent irrigation inspector.

The commission responds that municipalities with a population of 20,000 or more and water districts may adopt more stringent requirements in their local ordinances or rules than these minimum standards. The statute does not prohibit municipalities with a population of less than 20,000 from establishing local minimum standards for landscape irrigation systems. Smaller municipalities or districts may hire an independent irrigation inspector. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that TCEQ should prohibit the practice of requiring all ditches to be open with PVC pipe installed writing side up.

The commission responds that the adopted and previous rules have never required ditches to be open with PVC pipe installed writing side up. This may be a local requirement. The commission did not make any changes to the rules as a result of this comment.

Business Owners and Irrigators-in-Charge

Some commenters requested more definition and clarity of an "irrigator-in-charge A commenter questioned the use of the word "irrigator" in §344.64(a) and recommended that the correct usage is "irrigator-in-charge". A commenter stated that the phrase "irrigator-in-charge" should be added to §344.35(b), (c) and (d). A commenter stated that §344.71 should be changed from "irrigator" to "irrigator-in-charge". A commenter stated that the warranty references to "irrigators" should be changed to "irrigator-in-charge". A commenter stated that the provisions of §344.72(c) related to warranties for maintenance, alteration, repairs, or service were not needed since the provision was covered by an irrigator-in-charge.

The commission responds that an "irrigator-in-charge" role is to oversee irrigation services for an exempt business owner. The irrigator-in-charge would be responsible for all irrigation worked performed by the business owner. An exempt business owner must comply with the entire Chapter 344 rule requirements which include hiring a licensed irrigator to supervise the business's sale, design, consulting, installation, maintenance, alteration, repair, and service of irrigation systems. An irrigator-in-charge can work at his own business and for one exempt business at any given time. The irrigator-in-charge can perform all of the duties pointed out by the commenters for the exempt business owner. The commission did make changes to the definition of "exempt business owner" in §344.1(25) as a result of these comments to clarify that the irrigator-in-charge is employed by an exempt business owner.

Some commenters requested clarification of §344.34(c) asking if multiple crews at multiple job locations at the same time could work under one irrigator-in-charge. Some commenters stated that §344.34(c) should allow a licensed irrigator to work for numerous companies. Additionally, some commenters stated that the company should not be held responsible for having an irrigator-in-charge if they had an irrigator perform irrigation work. A commenter stated that a licensed irrigator should be able to work for as many companies as he or she wanted and that the responsibility should follow an individual. Some commenters stated that it is impossible for one person to oversee every aspect of an irrigation company and that the irrigator obtaining the permit should be responsible for the project or share responsibility with the irrigator-in-charge.

The commission responds that an irrigator-in-charge, working for an exempt business owner, may have multiple crews at multiple job locations at the same time. A licensed irrigator may work for an unlimited number of companies. The "irrigator-in-charge" designation applies only to those irrigators working for an exempt business owner. An irrigation company owned and operated by a licensed irrigator does not need to designate an irrigator-in-charge. Therefore, the irrigator-in-charge must limit his work with multiple irrigation entities to a level that he can reasonably provide supervision to ensure that the design and installation of irrigation systems are correct, that sales, consultation, providing customer service, obtaining permits, scheduling inspections and other related activities are appropriately supervised. The commission did not make any changes to the rules as a result of these comments.

A commenter requested clarification of (1) the responsibility of the irrigator-in-charge and irrigator working from an irrigation design prepared by a licensed irrigator and exempt landscape architects and engineers; and (2) the role of the irrigator-in-charge as the sole irrigator responsible for activities.

The commission responds that if an irrigator-in-charge, as designated by an exempt-business owner, or irrigator working from an irrigation design prepared by an irrigator, exempt landscape architect or engineer and installs the irrigation system as designed, the designing irrigator is responsible for the design of the system meeting state requirements. If the irrigator-in-charge, as designated by an exempt business owner, or irrigator makes changes to the irrigation system that degrades the design resulting in the system failing to meet the state standards, the installing irrigator-in-charge or irrigator is responsible for the system. The commission did not make any changes to the rules as a result of this comment.

Commenters asked if a business owner could sell an irrigation system without an irrigator's license. Commenters asked for clarification of an exempt business owner as the sole entity financially responsible for all irrigation activities and irrigation records. Commenters stated that §344.31 should address selling and connecting an irrigation system to the water supply. Commenters requested that language be added to clarify the role of an exempt business owner and that the business owner is responsible for all actions of the irrigator-in-charge while the irrigator is employed by the exempt business. Some commenters supported removing the provision for an irrigator-in-charge in the exemption for business owners.

The commission responds that an exempt business owner must employ a licensed irrigator, designated as an irrigator-in-charge, to be responsible for all irrigation activities conducted by the business. Since the irrigator-in-charge is designated by the exempt business owner to supervise all landscape irrigation activities, the irrigator-in-charge is responsible for those duties outlined in §344.35. The exempt business owner will be financially liable for irrigation activities and for irrigation records. The irrigator-in-charge is responsible for any enforcement actions that may be taken related to the sale, design, consultation, installation, maintenance, alteration, repair and service of irrigation systems, under the irrigator-in-charge's supervision. The day-to-day activities of supervision and direction of an installer or irrigation technician, selling, designing, obtaining permits, installing or servicing irrigation systems requires the full attention of the irrigator-in-charge. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that a definition for "business owners" should be added.

The commission responds that the term "business owner" is defined in Texas Occupations Code, §1903.002(c)(10) as "an owner of a business that employs an individual described by Subchapter F of this chapter who is licensed under Chapter 37, Water Code, to supervise the business's sale, design, consultation, installation, maintenance, alteration, repair, and service of irrigation systems". The licensed person in the reference is a licensed irrigator. The commission did not make any changes to the rules as a result of this comment.

Irrigators, Installers, and Irrigation Technicians

Some commenters stated that the responsibilities needed to be clarified to address an irrigator that performs only design work and an irrigator that performed only installations.

The commission responds that an irrigation designer is responsible for using the stamp or rubber seal appropriately, designing irrigation systems that comply with state laws and local regulations, determining the appropriate backflow prevention method for each irrigation system installation, maintaining landscape ir-

rigation system records, developing irrigation plans that comply with the requirements of Chapter 344, ensuring that when selling or consulting that the requirements of Chapter 344 are met and providing advertisements and contracts that comply with the Chapter 344 requirements. Changes were made to §344.35(d) and §344.63(2)(D) to clarify the separation of responsibilities for an irrigator that performs only design work. In addition, the language in §344.43 has changed to separate the responsibilities of an irrigator that performs design work and an irrigator that installs irrigation systems and to address the use of "design". The language in §344.43(b) has been changed to read "The presence of the irrigator's seal displayed above the irrigator's signature and date on any document constitutes the acceptance of all professional responsibility for the document and the irrigation services performed by the irrigator in accordance with that document". The change in the language reflects the acceptance of responsibility for the installation or design. The word "should" is enforceable since the investigator will be able to determine whether or not the work performed by a second irrigator is clearly identified. Changes were made to the rules as a result of these comments.

A few commenters requested clarification related to §344.35(d)(12), asking if a controller had to be replaced by another irrigator, whose sticker would be placed on the new controller.

The commission responds that the sticker would provide information to the irrigation system owner about the warranty period and information to contact the irrigator. If the irrigator is replacing a controller installed by another irrigator, it may be assumed that the original warranty is no longer valid. The irrigator installing the new controller would use his sticker for contact, should there be a controller warranty issue. The commission did not make any changes to the rule based on the comments.

A commenter stated that "water audits" should be added to the list of duties that an irrigator can perform, be listed in the license requirements, and in the definition of "irrigator".

The commission responds that water audits are the on-site survey and measurement of irrigation efficiency and the generation of recommendations to improve water management efficiency. TCEQ encourages the use of water audits as a tool to reduce water consumption. Since water audits were not part of the original proposal and including the task at adoption could be considered increasing the scope of the irrigator's job functions, the Administrative Procedure Act precludes making such changes without adequate public notice. The commission did not make any changes to the rules as a result of this comment.

A commenter stated that the definition of "irrigation technicians" was the same as the definition of "licensed irrigator" except that licensed irrigation technician could not design, sell or offer consultation on irrigation systems and this was redundant and a waste of time.

The commission responds that it better serves the definition to specify those responsibilities which the technician can perform, rather than to state he can perform all the responsibilities of an irrigator except to provide designing, selling, and consulting services. The commission did not make any changes to the rules as a result of this comment.

Some commenters suggested an alternative approaches such as multi-levels or of using an apprentice that would become a technician.

The commission responds that the suggested alternative approach of a multi-tiered license is outside the scope of the proposed rulemaking and including these changes at this point could be considered increasing the scope of the rules which could have a significant impact on existing and prospective applicants. The Administrative Procedure Act precludes making such changes without adequate public notice and giving parties an opportunity to comment on such issues. The commission did not make any changes to the rule as a result of this comment.

Some commenters stated that §344.34 was not enforceable because of the use of the word "may" rather than "should, must or shall".

The commission responds that the word "may" was changed to "shall" in §344.34(a) as a result of this comment.

An individual stated that "selling" should be included in the definition of irrigation services.

The commission concurs with the comment and has added the term "selling" to the definition of irrigation services in §344.1(20). The commission made changes to the rules as a result of this comment.

A commenter stated that all dates in §344.30 and §344.36 should be 2010.

The commission responds that the rules will go into effect on January 1, 2009, as mandated by HB 4/SB 3. The requirement to have a licensed irrigator or licensed irrigation technician on-site at all times during the installation, maintenance, alteration, repair, or service of the irrigation system will begin on January 1, 2010. That part of the rules was phased-in to allow time to develop the training, testing and licensing of sufficient irrigation technicians to meet the anticipated demand. The commission did not make any changes to the rules as a result of this comment.

Commenters stated that the duties of the irrigation technician should be changed to allow the irrigator time to perform other duties.

The commission agrees that the irrigation technician may assist the irrigator by sharing responsibility in the field. The language in §344.36 allows the irrigation technician to perform those duties. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that a "final walk through" should be added to the irrigator's responsibilities in §344.35(d).

The commission responds that the language is sufficient to allow the irrigator to perform the "final walk through" if the irrigator chooses to perform the duty. The commission did not make any changes to the rules as a result of this comment.

Irrigation Inspectors

Some commenters stated inspectors should not verify irrigation technician licenses.

The commission responds that the commission is granted authority under Texas Occupations Code, §1903.053 to administer the landscape irrigation program that includes enforcement. HB 1656 grants authority to municipalities and water districts to employ or contract with a licensed plumbing inspector, licensed irrigation inspector, or district operator for water districts, to enforce the adopted ordinances or rules. Verification of licenses is within the enforcement authority granted to the commission, mu-

nicipalities, and water districts. The commission did not make any changes to the rules as a result of this comment.

An individual stated that an inspector's duties should be changed to include a reference to the required design on-site.

The commission responds that the requirement to have a design on-site is covered in §344.61(a) and does not need to be included in §344.37(b)(3). The commission did not make any changes to the rules as a result of this comment.

Seal

IA and an individual stated that §344.40 could be interpreted to mean that the irrigator should have the seal at all times. Another commenter requested modification to include "stamp" because a seal seemed to indicate a metal embosser.

The commission responds that the intent of §344.40 is that an irrigator should not engage in any landscape irrigation services without the physical possession of a seal and the license. The irrigator should have the seal available for use on documents. The use of a stamp that meets the requirements of §344.41 is acceptable. The commission did not make any changes to the rules as a result of these comments.

IA requested clarification of the requirement to produce the seal within two days of the request.

The commission responds that irrigators are no longer required to submit to the executive director a duplicate impression of his seal on letterhead or business stationery or to notify the executive director of any changes in the seal. Since the irrigator is no longer required to submit the impression, the commission or another governmental entity may request a copy of the seal impression to investigate complaints. It should be noted that the requirement to provide records has been changed to provide records within ten business days. The commission did not make any changes to the rules as a result of this comment.

IA stated that the seal should not be required on the maintenance checklist. A commenter stated that the seal should be treated as a liability.

The commission responds that the maintenance checklist is a key item in educating irrigation system owners about the proper use of the irrigation system. The seal is not a liability. The use of a seal on documents usually indicates the acceptance of professional responsibility for the document and a professional service performed in connection with the document. The seal is an ethical and professional requirement that is used to hold a licensee to a higher standard of conduct and performance. The commission did not make to the rules as a result of these comments.

Some commenters stated that the only items that require a stamp are irrigator generated documents.

The commission responds that items that are not irrigator generated documents such as a manufacturer's warranty should not be sealed. The commission did not make any changes to the rules as a result of these comments.

Some commenters questioned if an irrigator should seal all pages of plans and specifications.

The commission responds that irrigators should seal only the cover or index page of a set of bound documents. A bound document could be stapled, glued or in a binder. If the document does not have a cover or index page or if the document is unbound, all pages should be sealed. Electronic documents should have the seal on each page. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that anyone could get a stamp or seal and asked why the seal was important.

The commission responds that the presence of the irrigator's seal and signature constitutes professional responsibility for the document and the irrigation services performed in accordance with the document and certifies that the system was properly installed. Upon being licensed by the commission, each irrigator is required to obtain a seal. Licensed irrigators may not engage in any landscape irrigation services without the physical possession of the seal and license. Any unlicensed person using an irrigator's stamp or seal or a licensed irrigator that does not use the stamp or seal appropriately is subject to enforcement action by the commission. The commission did not make any changes to the rules as a result of this comment.

A commenter stated that the preamble stated that the irrigator's signature should be below the seal, but §344.61 stated the signature should be over the seal, and §344.43 stated that the signature should be above the seal. A commenter stated that the location of the signature should be clarified so that the signature would not hide the name and license number of the irrigator.

The commission responds that the language in the preamble has been changed to reflect the correct location of the irrigator's signature, beneath the seal. The language in §344.61 related to seals and signature has been repealed effective January 1, 2009. The location of the irrigator's signature (beneath the seal) will not hide the name and license number of the irrigator. Changes were made to the preamble as a result of this comment.

A commenter stated that scanned signatures should not be applied to drawings because the signature can be applied by someone else without the irrigator looking at the drawing.

The commission responds that scanned signatures can be applied by someone else just as the irrigator's seal or stamp can be applied by someone else without the irrigator's review. The presence of the seal above the signature and the date indicate the irrigator's acceptance of professional responsibility for the document and that irrigators are responsible for the security of the seal. The commission did not make any changes to the rules as a result of this comment.

Backflow Prevention

Numerous commenters stated that the y-type strainer should be located on the inlet side of the backflow prevention device, some commenter stated a strainer was not needed, or was needed when water was from a lake, river, pond or well.

The commission responds that the purpose of a y-type strainer is to prevent debris from going into the double check valve and possibly preventing the double check valve from operating correctly to prevent contamination of the water supply. The y-type strainer should be located on the inlet/supply side of the double check assembly. A change was made to §344.50(e)(3) the rules to indicate the correct location of the y-type strainer.

Some commenters supported locating double check valves underground, one commenter stated that some double checks have ferrous plugs and installation below ground could create problems and other commenters stated the double check backflow prevention device should be installed above ground.

The commission responds that double check valves may be installed below ground per industry standards. In order to be in compliance with §344.50(e)(2), test cocks on double checks installed below ground are to be made of non-ferrous material. Irrigation systems that do not have chemicals injected into the system are a non-health hazard, so a double check valve is acceptable. Local areas may have more stringent standards. The commission did not make any changes to the rules based on these comments.

Some commenters stated backflow devices should be tested annually. One commenter requested clarification of why an irrigation system was not considered a high hazard. Another commenter requested language that would clearly state all backflow devices had to be tested at installation.

The commission responds that in a health hazard situation where there is the potential to introduce a substance into the potable water supply that could cause death or illness, spread diseases, or that has a high probability of causing death, illness, or spreading diseases, the backflow prevention device must be inspected annually. Backflow prevention devices that are used in situations that are identified as non-health hazard must be tested upon installation. Local areas may adopt more stringent standards that would require a test annually or at another interval. The Chapter 344, Landscape Irrigation rules are consistent with the requirements of the Public Drinking Water in Chapter 290 rules which identify irrigation systems without chemical additives as non-health hazards. The commission did not make any changes to the rules as a result of these comments.

A commenter asked for clarification of why other backflow prevention devices are allowed if a chemical is added to an irrigation system. An individual questioned if §344.51(a) had always been a reduced pressure principle. A commenter stated that "chemical" should be defined.

The commission responds that a reduced pressure principle backflow prevention assembly device is the most effective mechanical assembly. The reduced pressure principle backflow prevention assembly device is required when a chemical is added to an irrigation assembly. The definition of "chemical" has not been added to the rules since it is taught in basic irrigation training course. The commission did not make any changes to the rules as a result of these comments.

Cross-Connections

A commenter stated that the definition of "cross connection" in §344.1 and §290.8 were different and that an actual or potential connection is not the same as a physical connection.

The commission responds that the definitions found in Chapter 344 are specific to the Landscape Irrigation Program. The definitions found in Chapter 290 apply to Public Drinking Water Systems. Certain terms are defined in both chapters, but due to the different focus of these chapters, the definitions have been tailored to either landscape irrigation or public drinking water systems. When evaluating compliance with the regulations of these two chapters, individuals should ensure that the definitions being used correspond to the appropriate chapter. The commission did not make any changes to the rules as a result of this comment.

Some commenters support the restrictions on cross connections. Some commenters stated that the way §344.51(b) was written would discourage rainwater harvesting and the interconnection of potable and non-potable water source should be allowed if a reduced pressure principle backflow prevention device was installed. A commenter stated that adding an isolation valve and limiting the connection to a secondary back-up supply, one source at a time should be allowed. Some commenters questioned why the language was included. A commenter requested clarification of the requirement in §344.51(b) that would prohibit the interconnection of potable and non-potable water sources in an irrigation system and stated that proposed §344.75(c) allowed the interconnection through a "high health hazard" backflow prevention device.

The commission responds that §344.75(c) will be repealed through this rulemaking. Based on these comments, however, a change was made to §344.51(b) to allow the interconnection of a potable and non-potable water source with a reduced pressure principle backflow prevention assembly or an air gap. A change was also made to remove §344.65(3) to allow the use of reclaimed water in irrigation systems connected to the potable water supply if a reduced pressure backflow prevention device or air gap is used.

A commenter stated that the difference between "aspirated" and "injected" additives should be clarified and a commenter stated that §344.51(a) should be modified to include the phrase "or injected", while another commenter stated that §344.51(c) should be modified to include the phrase "induced during the manufacturing process" to better clarify the rules.

The commission responds that the reduced pressure principle backflow prevention assembly device is the most effective backflow prevention device, therefore the reduced pressure principle backflow prevention assembly device is required whenever chemicals are added (by aspiration or injection) to an irrigation system. The commission agrees that §344.51(c) should be modified to include the phrase "aspirated, injected, or emitted from a chemical delivery system" to clarify the requirement that a reduced principle backflow prevention assembly is needed for any type of chemical used in conjunction with an irrigation system. The modified language has been added to §344.51(c) as a result of these comments.

A commenter stated that §344.75 conflicts with §344.51(b) and that the term "high health hazard" should be changed to "health hazard".

The commission responds that the language in §344.75 is repealed by this rulemaking. The commission has adopted §344.51 to replace §344.75. Section 344.51 does not contain the term "high health hazard", the commission did not make any changes to the rules as a result of this comment.

A commenter stated that "major maintenance, alteration, repair, or service" was defined but was not used in the rules and recommended using the phrase in §344.36(d)(2). Several commenters supported the requirement to require a backflow prevention device during major maintenance, alteration, repair, or service was conducted.

The commission responds that "major maintenance" was used in §344.52(a) which describes when a backflow prevention device must be installed during the maintenance, alteration, repair, or service of an irrigation system. An irrigation technician may provide on-site supervision of all maintenance activities so the term "major maintenance" was not added to §344.36(d)(2). The commission did not make any changes to the rules as a result of this comment.

A commenter stated that §344.52(c) which requires an irrigator to test the backflow prevention device prior to being placed in ser-

vice, should have "in service" defined, and another commenter stated that irrigator should be given 30 days to provide the test report to the water purveyor.

The commission responds that the language in §344.52(c), the term "in service" refers to when the irrigation system is fully operational, has been successfully tested, and verified acceptable for use. The irrigator should schedule and coordinate the test of the backflow prevention device with the backflow assembly tester to protect the water supply. The irrigator should be able to provide the test report to the water purveyor within the ten business days provided in §344.52(c). The commission did not make any changes to the rules as a result of these comments.

Design and Installation Requirements

Spacing - some commenters stated that sprinkler heads should be installed no closer than two inches from a hardscape rather than four inches and one commenter stated that the term "impervious surfaces" covers everything and the list is not needed. Some commenters supported changing the requirement that the area where the above ground emission devices shall not be installed should be four feet or less in length or width some supported five feet or less, one commenter supported eight feet or less, and some suggested clarifying the way the area would be measured. A commenter stated that watering across narrow impervious surfaces should be considered in certain situations.

The commission responds that pop-up spray or rotary emission devices that are closer than four inches to a hardscape waste water because there is some water back throw from emission devices. Allowing four inches of spray will allow more soil to absorb the water. The examples of impervious surfaces were meant to clarify and provide examples of items that the commission considers to be an impervious surface. The commission agrees that there are strip nozzles that can cover areas that are 48 inches or less without watering hardscapes and has changed the rules to allow the 48 inches requirement, but has altered the language to ensure that the measurement relates to soil and not curbs, pavement or other hard surfaces. The commission also recognizes exceptions from the requirements in some limited instances, such as narrow meandering paved walkways, jogging paths, golf cart paths, cemeteries, or other small impervious areas that should be exempted from the requirement because more water would be used in avoiding spraying water onto the surface than the small amount that might run off the paved surface. The commission changed §344.62(b)(2) and added §344.62(b)(3) to address the concerns. The commission made changes to the rule based on these comments.

Water pressure - Some commenters requested clarification of the water pressure requirement related to emission devices.

The commission responds that the intent of the rules is to clearly state that the installation of an emission device that operates below the minimum or above the maximum sprinkler head pressure published by the manufacturer is a violation of the Chapter 344 requirements. Flow control valves, a pressure regulator, or pressure compensating spray heads are methods that could be used if the pressure is too low. The commission did not make any changes to the rules as a result of these comments.

Piping - One commenter stated that the requirement should be completely revised to reflect mainline and lateral line piping. Another commenter disagreed with the preamble's phrase "thus wasting water". A commenter stated that main line and lateral piping would have to be sized.

The commission responds that the purpose of the limit is to minimize the surge damage done to pipes, which can lead to breaks and leaks which lead to wasted water. The accepted limit in irrigation design is five feet per second for PVC pipe. The national IA's "Foundations of Landscape Irrigation Design" states that the velocity limit technique is the most common method to size pipe. Placing the commonly accepted industry practice in the rules will lead to long term water conservation. The commission did not make any changes to the rules as a result of these comments.

Zones - Some commenters asked for clarification of "hydrological requirements", "plant material", "microclimate", and "topographic". A commenter opposed requiring separate zones based on plant and soil type. Some commenters stated that irrigation zones should not be based on microclimate, hydrological requirements, and soil conditions. One commenter stated that the rules would create more zones than were needed. Another commenter stated that the requirement is too vague from an enforcement standpoint.

The commission responds that HB 4/SB 3 directed the commission to adopt rules that address the design and installation of irrigation systems and water conservation. Correctly addressing the hydrological, plant material, microclimate, and topographic requirements are key components of design, installation, and water conservation. The commission considers microclimate to be items like structures, paved areas, shade, wind conditions, or direct sunlight. Topographic conditions refer to the slope (which can influence the pressure of the sprinkler system) and the elevation (related to runoff) and grade (a slope in connection with drainage). Hydrological requirements are the groupings of like emission devices so that the maximum gallons per minute of available flow is not exceeded and performing the calculations to determine that the system will operate efficiently. The IA's "Foundations of Landscape Irrigation Design" manual dated March 2002 states that the basic information that should be discussed with the owner (or owner's representative) includes hydrozones and microclimates (page 4 and 5). The document explains that a hydrozone is an area containing plants that will be irrigated on the same schedule using the same irrigation method. The commission considers turf, trees, and flower beds as areas that should be on different zones. The manual explains that the information may be obtained from a planting plan or an actual site survey. The manual also states that "microclimates are relatively easy to identify" and that the variations in environmental conditions are important to sprinkler selection, zoning and scheduling. These concepts are taught in basic irrigation courses and continuing education courses that are required to maintain irrigation licenses in Texas. These items can be observed and documented, so they can be enforced. A trained inspector will be able to tell the difference between a poorly designed and installed irrigation system that would have trees and turf on the same zone. A trained inspector can observe differences in a microclimate and determine if the system has been zoned appropriately. The commission did not make any changes to the rules as a result of this comment.

Matched precipitation rates - A commenter stated that the requirement should include a performance standard, such as within 20%.

The commission responds that §344.62(f) requires that zones must be designed and installed so that all of the emission devices in that zone irrigate at the same precipitation rate to ensure uniform application of water. Not having a matched precipitation rate will result in over watering or under watering areas of the

zone. The commission did not make any changes to the rules as a result of this comment.

Spraying water - A commenter stated that the requirement should be removed because on-the-job training would address the requirement. Two commenters said the rule would be impossible to enforce. One commenter recommended not allowing a design with overspray in a zero wind condition. Another commenter stated that a tolerance factor should be provided.

The commission responds that any violation that can be observed and documented can be enforced. Trained inspectors know that even well-designed and installed systems may overspray when it is windy. They will also know that the law is intended to address systems which are designed and installed poorly without regard to surrounding impervious surfaces. An example of a poorly designed and installed irrigation system would have a full circle emission device located next to a driveway or sidewalk and spraying on the driveway or sidewalk compared to a well designed and installed irrigation system that has a quarter circle emission device located next to a driveway but spraying on the driveway. The agency removed minimum wind derating standards from the adopted rules because the requirement was dated and new technology can address the issue. The commission agrees that on the job training will help improve the quality of the irrigation systems installed. The commission did not make any changes to the rules as a result of this comment.

A commenter stated that the requirement should be modified to not allow water to run into a municipal storm drain.

The commission responds that the adopted rules will reduce the runoff to municipal storm drains by minimizing the spray of water on sidewalks, streets and other paved surfaces as contained in §344.62(g). The commission did not make changes to the rules as a result of this comment.

Master Valve - Some commenters supported requiring master valves, other commenters requested clarification of the requirement (if any) and suggested alternative language, some commenters stated that the rule could not be enforced. An individual stated that the language in §344.62(h) should be changed from "if required" to "when required" to correctly reflect where the master valve should be located. Another commenter stated that the master valve does not conserve or protect the water supply.

The commission responds that a master valve closes when leaking water is detected. There are instances where a master valve may be installed, such as when an irrigation system is installed at a second home or when the owner is a frequent traveler and would not see that the irrigation system is malfunctioning. When leaking water is detected, a master valve controls the flow of water to the remainder of the irrigation system. When the irrigation system does not operate, the master valve is closed, so the irrigation system is not under pressure. Since the irrigation system is not subject to constant pressure, the system should last longer. This conserves water. In response to these comments §344.62(h) has been changed to read, "When provided, a master valve shall be installed on the discharge side of the backflow prevention device on all new installations".

PVC pipe primer solvent - Numerous commenters supported removing the requirement, a commenter stated that on-the-job training would address the requirement and another commenter stated that requirement was not enforceable. Some commenters suggested making the requirement optional. Some commenters supported the requirement with some changes such as in accordance with manufacturer's guidelines or in accordance with plumbing codes. A few commenters did not support requiring the use of purple primer. IA commented that colored primer should not be required on any pipes that are above ground. A commenter stated that colored primer will not promote water conservation.

The commission responds that primer helps to prepare PVC pipe for cement to ensure a long-lasting connection. If primer is not used, the connection may degrade faster and cause leaks that lead to wasted water. Some manufacturers have stated that primer may not be needed in some instances. To be consistent with various manufacturers recommendations, the rule language is being changed to reflect that primer should be used in accordance with either the Uniform Plumbing Code (Section 316) or the International Plumbing Code (Section 605). The use of colored primer on pipes that are above ground could be unsightly if the primer is not applied correctly. The correct application of primer will result in a faint purple cast less than an inch wide on the pipe. The use of colored primer will allow an inspector to easily identify that primer has been used. Changes were made to §344.62(i) as a result of these comments.

A commenter stated that the correct reference should be "primer and solvent".

The commission responds that the correct term is "primer and solvent" however, the industry jargon is "primer solvent" so that term was used. The commission did not make any changes to the rules as result of this comment.

Rain or moisture shut-off device - A commenter stated that automatic weather or sensor based controllers should be used on all installed systems and that a large system should be solar powered and isolated from the electrical grids if possible and provided suggested alternative language. A commenter suggested a definition of "weather or sensor based irrigation controller".

The commission responds that there is insufficient information on the EPA's WaterSense program's expectations or specifications for controllers at this time, and is therefore reluctant to mandate their required use until the specification is developed. The commission supports the use of solar powered controllers, and encourages governmental entities to consider their use when practicable. Since weather or sensor based irrigation controllers are not required, a definition is not needed. The commission did not make any changes to the rules as a result of this comment.

Commenters suggested deleting the requirement for rain or moisture sensor or other technology because on-the-job training can address the requirement and it would be impossible to enforce. A commenter supported the requirement to install rain sensors. Other commenters stated that sensors should be required but not in the El Paso or West Texas area because of the area receives little rainfall. Another commenter stated that language could be added that would allow areas of the state with extreme climates dictate the type of sensor used.

The commission responds that the counties of El Paso, Hudspeth, Culberson, Jeff Davis, Presidio, Brewster, Terrell, Loving, Winkler, Ward, Reeves, Ector, Crane and Pecos have low annual rainfalls (according to the 2006-2007 Texas Almanac) and have been exempted from the requirement to have a rain or moisture shut-off device or other technology. A trained inspector can verify that a rain or moisture shut-off device or other technology is installed and operational so it can be documented and is enforceable. The commission has changed §344.62(j) based on this comment.

Some commenters supported a rain/freeze sensor on every irrigation system.

The commission responds that the requirement for a freeze sensor was considered. The use of a freeze sensor is more responsive to safety issues than to water conservation. The determination to require a freeze sensor is best made at the local level. The commission did not make any changes to the rules as a result of this comment.

A few commenters stated that rain moisture or shut-off devices should be required on irrigation systems that are repaired as well as those that are replaced.

The commission responds that an irrigator should inform customers of the potential water and cost savings involved in adding sensors to systems that are repaired. Because adding sensors can include laying additional wire from the sensor to a controller, the addition of a rain or moisture shut-off device or other technology could cost the consumer much more than the original requested repair. A requirement to retrofit irrigation systems was not included in the proposal. Local areas may have requirements that would require the installation of a rain or moisture or other shut-off device. The commission did not make any changes to the rule as a result of this comment.

A commenter stated that it should be clarified that water purveyors could require other devices.

The commission responds that the rules are minimum standards and water purveyors may require other technology. The commission did not make any changes to the requirements as a result of this comment.

A commenter stated that excess flow sensors should be required as shut-off sensors for large systems (greater than or equal to one acre).

The commission responds that while there may be a benefit for some systems, an excess flow sensor is not being mandated state wide. The sensors may be mandated locally as necessary to help ensure water conservation goals and objectives are met. The commission did not make any changes to the rules as a result of this comment.

Isolation Valve - Some commenters supported requiring an isolation valve, some supported requiring all irrigation systems to have an isolation valve. Some commenters said that training could replace the requirement and that the requirement could not be enforced. A commenter suggested requiring that the isolation valve have a "lock out" feature. One commenter stated that an isolation valve does not conserve water. One commenter requested a definition of "isolation valve".

The commission responds that local government representatives strongly supported the requirement to have an isolation valve so that water to the residence or commercial building would not be interrupted while turning off the water to a malfunctioning irrigation system. Local areas can require a "lock out" feature on isolation valves. An "isolation valve" is a shut off point for all water in the irrigation system. The isolation valve will allow a system owner to easily turn off water to the irrigation system when leaks are detected. This will conserve water. A requirement to retrofit a system to add an isolation valve was not included in the proposal because it could increase the cost of repairs or maintenance or alteration to the irrigation system. However, local areas may have more stringent requirements. Trained inspectors will be able to observe the isolation valve and determine compliance with the requirement. The commission agrees that on-the-job training will be needed to respond to the new rules. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that an additional main shutoff valve be required if the system is not on a separately valved meter or if the backflow prevention device does not have a shut off valve. A commenter stated that the requirement should specify whether or not the required isolation valve can be supplied as part of the backflow assembly.

The commission responds that the rule requires only an isolation valve between the water meter and the backflow prevention device so that the water can be turned off to the irrigation system if the backflow prevention device is being repaired or replaced or the irrigation system is malfunctioning. The commission did not make any changes to the rules as a result of this comment.

Depth Coverage of Pipe - A commenter stated that parts of Texas have very rocky or even solid rock a few inches below the existing soil and that mounding dirt over the pipe and wire should be allowed. IA commented that a better definition of "returned to grade" was needed.

The commission responds that the purpose of requiring the fill material to be returned to the original grade was to prevent a safety hazard with fill material that was not level. In the instance described by the comment, mounding the dirt to provide adequate coverage would be sufficient. The contract and as-built drawing should contain information clearly identifying the reason that the dirt would be mounded over the pipe or wire. The irrigator should also consider whether or not there would be any additional maintenance requirements or recommendations for the irrigation system owner as a result of the mounding. The irrigator should also work with the irrigation system owner to address all safety concerns related to mounding dirt over the pipe or wires. The term "returned to grade" is the highest (pre-installed irrigation system) ground level immediately adjacent to the pipe or wire being covered and should be compacted sufficiently to be at grade at the time the irrigation system is completed. Changes were made to the depth of pipe coverage requirements in §344.62(l)(1) as a result of this comment.

Commenters suggested a definition of "select backfill". A commenter stated that a definition of "compaction" was needed.

The commission responds that the definition of backfill, "free of building debris and rocks larger than two inches" is an industry standard and is taught in basic irrigation training courses and in continuing education courses needed to maintain irrigator licenses. "Compaction" or compressing backfill is taught in basic irrigation courses and continuing education courses that are required to be licensed to perform irrigation work in Texas. The commission did not make any changes to the rules as a result of these comments.

Wiring irrigation systems - A commenter stated that the wording related to electrical wiring splices, should be changed to "which may be exposed".

The commission responds that §344.62(m)(3) has been made to change the phrase to "which may be exposed" in response to the comment. The change to the rule has been made in response to the comment.

Water in piping - A commenter stated that §344.62(n), relating to water in the piping of an irrigation system being non-potable, was too long and provided an alternative layout.

The commission appreciates the comment. Since the language did not change, the commission did not make any changes to the rules.

Completion of irrigation system installation - A commenter stated that the definition of "Completion of Irrigation System" was not needed since the definition was standard business practice.

The commission responds that the definition is needed to provide clarity to §344.63, Completion of Irrigation System Installation. The commission did not make any changes to the rules as a result of this comment.

Maintenance, Alteration, Repair, or Service of an Irrigation System

Several commenters stated that the requirement in §344.64 to add an isolation valve when repair is done at the water meter or backflow device is unenforceable. A commenter stated that the installation of an isolation valve should be limited to instances when the backflow prevention device is replaced. One commenter stated that §344.64 would require a repair for one broken head to result in a y-type strainer, backflow device, master valve, isolation valve, rain/freeze sensor, select materials, etc. and would result in lost business.

The commission responds that a change has been made to §344.64(d) to clarify that an isolation valve should be installed when a repair requiring excavation is made at the water meter or backflow prevention device, if an isolation valve is not present. The intent of the rule is that when performing any work on the meter or backflow prevention device that requires excavation, an isolation valve should be installed. This would include situations where excavation work is performed at the meter or backflow prevention device during repair or replacement. An isolation valve will allow water to be shut off to an irrigation system while allowing water to go to a residence or building. Being able to turn off water to a malfunctioning irrigation system will conserve water. The rule does not require a y-type strainer, backflow device, isolation valve, master valve, or a rain/freeze sensor if one broken head is repaired. Instances of non-compliance reported or noted during inspections can be verified by review of homeowner or irrigator records. The adopted section, §344.64(d), was revised to state that excavation work at the meter or backflow device will trigger the installation of an isolation valve on an existing system. The commission made a change to the rule as a result of this comment.

A commenter stated that §344.64 should be changed so that an irrigator would not be held responsible for negligence by the irrigation system owner, another commenter stated the requirement does not adequately place responsibility for the work performed.

The commission responds that the irrigator does not violate §344.64 if the owner is negligent. The irrigator is responsible for all work performed under the irrigator's supervision. The commission did not make any made changes to the rule as a result of these comments.

A commenter stated that §344.64(c) should include "solvent used when solvent welding PVC pipes and fittings" because some components do not require primer or cement.

The commission responds that §344.64(c) has been changed to reflect the modifications made to §344.62(i). Changes were made to the rules as a result of this comment.

Reclaimed Water

A commenter questioned the form of Spanish was required on the sign to comply with §344.65(6), Reclaimed Water. Another commenter stated the actual text should be included in the rule.

The commission responds that the actual Spanish language would be "Agua de recuperación - no beber". The commission made changes to §344.65(b) as a result of the comment.

A commenter stated that §344.65 should have two sections - one for reclaimed water and one for gray water. A commenter stated that §344.65 needed to be revised to address retrofitting an existing system. Some commenters suggested adding new definitions for "well water, recycled water, gray water, rain harvesting and reused water".

The commission responds that gray water and retrofitting of irrigation systems to use reclaimed water were not addressed in the proposed rules. Including changes at this point could be considered increasing the scope of the rules which would have a significant impact on the regulated industry and citizens. The Administrative Procedure Act precludes making such changes without adequate public notice and giving parties an opportunity to comment on such issues. The definitions for recycled water, gray water, rain harvesting, and reused water are not needed since they are not used in Chapter 344. The term well water, as used in the irrigation industry, is any water that is located beneath the surface of the ground and is not under the direct influence of surface water. The commission did not make any changes to the rules as a result of this comment.

Advertisement, Contracts, and Warranty

Commenters recommended deleting the requirement that the name, address, and telephone number of the TCEQ be displayed at the structure where irrigation business was conducted. Some commenters stated that if required, the sign should be provided by TCEQ.

The commission responds that the requirement to display commission contact information is required in the current rules (§344.93(d)), but was slightly modified to indicate the sign should be located at the "irrigation business" rather than at the "business". The requirement is for the purpose of directing complaints. To clarify the requirements, §344.70(c) was modified to include the phrase "for the purpose of addressing complaints". HB 4/SB 3 directed the commission to adopt and enforce rules related to landscape irrigation. In order to properly enforce rules, the public must know that the commission regulates irrigation services in Texas. Other businesses that have signs for directing complaints are physicians' offices, barber, and beauty shops. The commission made changes to the rule as a result of this comment.

A commenter stated that there is no mention of a license number on a trailer in §344.93 but it was mentioned in §344.70. Some commenters stated trailers should be removed from the rules because they are often rented, another commenter stated that the license number should be required for vehicles and trailers used in the installation, maintenance, alteration, repair, service, permitting or connection of an irrigation system to a water supply. A commenter stated that the advertising requirements should be changed to read "irrigator-in-charge" rather than "irrigator". A commenter requested clarification when multiple irrigators worked for one company.

The commission responds that the license number on a trailer containing advertisements of irrigation services is a requirement of the adopted rules that will be effective January 1, 2009.

The language in §344.93 has been repealed. The language in §344.70(a) was changed to clarify the services that the requirement applies to. All vehicles used in the performance of irrigation system installation, maintenance, alteration, repair, or service must display the irrigator's license number. A licensed irrigator will desire to use the trailer to advertise services and would want to make the license number available. An unlicensed irrigator will be unable to provide the license number. Companies with multiple irrigators may comply with the requirement in one of two ways: use the license number of one employee in all advertisements, on all vehicles, etc. or may use any or all of the licensed irrigators' number in advertisements or on vehicles. Changes were made to §344.70(a) and (b) as a result of these comments.

A commenter asked if magnetic signs were allowed.

The commission responds that magnetic signs are acceptable. The commission did not make any changes to the rule as a result of this comment.

Some commenters stated that contracts for the installation of irrigation systems should not be required to be in writing as outlined in §344.71.

The commission responds that HB 4/SB 3 required the commission to adopt rules that address the design, installation, and operation of an irrigation system, the conservation of water, and the duties and responsibilities of an irrigator. A written contract is a responsibility of an irrigator because it clarifies the terms and conditions for the design, installation and operation of the irrigation system. The IA's Handbook states that a written contract is a guarantee of professional work and urges the consumer to insist on a written contract, "no matter what the amount". The commission did not make any changes to the rules as a result of this comment.

Some commenters asked how the "pass-through contract" provisions would be enforced against non-irrigation companies

The commission responds that it is a violation of the Chapter 344 rules for anyone other than a licensed irrigator or exempt person to sell, design, consult, maintain, alter, repair, or service an irrigation system. The commission or locality would take appropriate enforcement action against the unlicensed individual installing an irrigation system. In addition, the definition of "pass-through contract" in §344.1(36) has been changed to provide clarity to the rule. The commission did not make any changes to the rules as a result of this comment.

Some commenters recommended deleting the requirement that the contract must include the dates the warranty is valid.

The commission responds that it is sufficient to tie the warranty to a specific event, such as 365 days after the maintenance checklist is provided to the irrigation system owner or representative or 180 days after the backflow prevention device is tested. The commission did not make any changes to the rules as a result of the comment.

A commenter stated that the pass-through contract provision prohibiting monetary compensation be changed to clearly indicate that only a licensed irrigator can perform irrigation services.

The commission responds that the pass-through contract provision prohibiting monetary compensation has been removed. Chapter 344 states that only a licensed irrigator can perform irrigation services so it would be redundant to add language to the section. The commission made changes to §344.71(c) as a result of these comments.

Some commenters stated that a written warranty should not be provided to new irrigation system owners and that if provided, the warranty should not contain the irrigator's name, license number, business address, confirmation that the owner received a copy of the warranty and notification that irrigation is regulated by the TCEQ. IA supported removing the warranty requirement since some providers will not provide a warranty due to site conditions or due to other concerns. Some commenters stated that warranty requirements should be optional. Other commenters stated that the commission should require that the owner be advised whether or not there is a warranty. Some commenters stated that a warranty should be provided. Some commenters stated that a warranty period should be defined. Some commenters stated that irrigation system's owner or owner's representative should not have to sign the receipt of the warranty.

The commission responds that the requirement for a warranty for a new installation has been in the rules for several years (see §344.96). The irrigation system owner or operator must know how to contact the irrigator in order to obtain repairs or adjustments to the irrigation system. The commission agrees that the license number of the irrigator is not needed on the warranty since the irrigator's license number is on the seal and the owner should possess several items with the irrigator's license number and has deleted that requirement from §344.72(b). The commission was directed by HB 4/SB 3 to adopt and enforce rules that relate to the design, installation, and operation of the system, water conservation, and the duties and responsibilities of irrigators. It is appropriate that owners or operators of irrigation systems be able to contact the commission if there are complaints or concerns about the irrigation system. The warranty provides the irrigation system owner or operator an assurance that the new system will operate as efficiently as possible, and that if problems are encountered, that the irrigator will make the repair. Timely repairs will help conserve water. In addition, the IA's Handbook states that a good irrigation contractor will offer a one year written warranty on work performed. Commercial grade irrigation system components are generally warranted by the manufacturer for a period of one, three, or five years. An irrigation system will last twenty years or longer. A system that does not perform as efficiently as possible will use extra water for the life of the irrigation system. It is acceptable to provide the length of time that the warranty is valid if there is an easily determined trigger date such as the date the Maintenance checklist is signed by the irrigator or the date the backflow prevention device is tested. The commission made a changes to §344.72(b) as a result of these comments to remove the requirement to include the license number in some documents.

Some commenters stated that the warranty requirements should be removed and the seal serve as the guarantee. Other commenters stated that the City of El Paso required a bond and license be submitted to the city or for some occupations to the state as part of license registration requirements.

The commission responds that the requirement for a warranty has been in the rules for several years (see §344.96, Warranties). The warranty provides details and duration to the system owner or operator. The seal would not provide this information. The irrigation system owner or operator must know how to contact the irrigator in order to obtain repairs or adjustments to the irrigation system. The commission is not granted authority under Texas Occupations Code, Chapter 1903.053

to require bonds for irrigators as a condition of license. The commission did not make any changes to the rules as a result of these comments.

Some commenters stated that a warranty will not help water conservation.

The commission responds that a system warranty should represent a commitment for extended service after the sale. Prompt repairs and corrections will help conserve water. There may not be one single item that will help conserve water, but it is the combination of various efforts that include warranties that will accomplish this objective. The commission did not make any changes to the rules as a result of this comment.

IA commented that breaking down materials and labor when a repair is made will require an accounting change to account for changes in sales tax liability and will create a burden to small businesses. Some commenters stated that time and materials should not be required for service, that TCEQ should not dictate billing procedures, and that time and material details should not be provided. A commenter stated that time and material cannot be determined before hand.

The commission responds that any of the parts that were used in the maintenance, alteration, repair, or service of the irrigation system should be clearly identified on the invoice. This may help the irrigation system owner and irrigator with historical parts records and also help the system owner identify replacement parts to ensure the irrigation system is efficiently maintained and operated. If the irrigation system owner knows that a 30-foot spray emission device was installed, the owner will be less likely to replace it with a 20-foot spray emission device. It is possible to use a "lump sum" invoice and still identify the parts that were used in the repair. Changes to §344.72(c) have been made to not require labor to be included in irrigator documents provided to the irrigation system owner. The change includes requiring the parts that are used to be clearly identified in the invoice provided to the irrigation system owner or operator. Changes were made to §344.72(c) as a result of these comments.

Some commenters stated that a warranty should not be required for maintenance, alteration, repair, or service of an irrigation system, some commenters support optional warranties, and other commenters support requiring a warranty. Other commenters stated that the owner should be advised that there will or will not be a warranty. Some commenters stated that not all equipment warranties pass-through to the consumer and are a trade warranty obligation only to the provider. IA commented that irrigators could provide a clear statement of whether or not a warranty exists and provide the details of the warranty.

The commission responds that it may be difficult to provide a warranty for items such as reprogramming the controller, performing a water audit, completing an operation inspection or other items. The requirement to provide a warranty for maintenance, alteration, repairs, or service to an existing irrigation system has been removed. Changes were made to §344.72(c) as a result of these comments.

Some commenters stated that the commission should have no authority to require warranties and that warranties and business practices should not be adjudicated by the commission.

The commission responds that one of the most common complaints received by the commission relates to warranty work on irrigation systems. The warranty requirement helps conserve water. A system owner that has warranty coverage is more likely to call the irrigator when the irrigation system malfunctions. Small leaks or over watering is more likely to continue if the owner has no system warranty. Providing a warranty is not only good business practice, it can also result in saving water. The warranty requirement was in the previous rules (see §344.96, Warranties.). The legislature passed extensive laws with regard to the landscape irrigation program, but did not make any changes pertaining to that particular rule. The commission did not make any changes to the rules as a result of these comments.

A commenter requested clarification of "remodeling and renovation" related to warranties.

The commission responds that warranties are required for new system installations. However, the commission would encourage an irrigator to provide a warranty on a remodeling or renovation project that would involve significant new parts and redesign of the irrigation system that was a significant financial investment to the irrigation system owner. The commission did not make any changes to the rules as a result of this comment.

Irrigator Advisory Council

IA stated that excluding individuals involved in leadership in local and state irrigation associations limits the pool of irrigators and could explain some of the resistance to the rules. Some commenters stated that the word "practicing" should be added to §344.80(b). Another commenter stated that "and active in the business" should be added. Some commenters stated that "or consanguinity" should be removed from §344.80(d). A commenter asked for clarification of "officer of a trade association" and asked if a board of trustees' member is eligible for membership.

The commission responds the rule has been changed to be consistent with 30 TAC Chapter 5. The change will be effective January 1, 2009. A board trustee is considered to have some control of decisions made by an association and is considered to be an officer. The rule does not distinguish between statewide and local associations. The term "practicing" was not included in the rule because the language in the Texas Occupations Code, §1903.151(a)(1) does not require "practicing" irrigators. The commission made changes to §344.80 as a result of these comments.

A commenter stated that some council members have not acted fairly or ethically, controlled the flow of information, and will reap financial gain upon adoption of the rules.

The commission responds that there was an August 10, 2007 meeting held in Austin for communicating concerns or thoughts for the rules revision. The council accepted written comments prior to, and after the meeting. The commenters did not provide information to support the allegation that some members of the council will reap financial gain. Volunteer members of the Council canvassed the state for input into the rules process. During a multi-week period two council members visited over ten cities around the state to obtain local input from local associations and irrigators. The council members donated their business and personal time to conduct this outreach effort. The commission did not make any changes to the rules as a result of these comments.

No Authority

A commenter stated that there should be incentives for conserving water and discounts for utilizing devices such as smart controllers, master valves, rain sensors, low-volume and xeriscape

designs or water restrictions. These measures would correctly place the responsibility of conserving water on the user since the public is responsible for over watering, watering out of season, and out of ignorance because water costs are so low. A commenter stated that requiring a person to sign a form stating that they are aware that a licensed irrigator must install the system and if an unlicensed individual installs the irrigation the system that the owner and installer can be fined a minimum of $500.00 and the installer more on each following illegal installation. IA stated that an additional means to protect the public would be to establish an insurance requirement that would define necessary coverage and limits. IA commented that TCEQ should be added as a certificate holder to each irrigator's insurance policy to facilitate notification of changes or voids in required coverage. IA further stated that if a void, lapse, or a deficiency in coverage happened, the irrigator's license would be revoked. A commenter stated that the majority of defective irrigation systems were designed and installed by unlicensed individuals, and that the commission should restrict the sale of PVC piping in sections longer than four feet to licensed irrigators only, because it would stop illegal installations and asked if the commenter could get credit or a reward for the idea. A commenter stated that new neighborhoods should be required to install reclaimed, gray water and untreated water systems with the sewer lines and that treated water should not be used to water landscapes. A commenter suggested using home owner associations to collect fees to be used to inspect, repair, or replace sprinklers to meet new standards.

The commission appreciates the suggestions but does not have the authority to mandate or implement the suggestions. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that homeowners should not be allowed to install their own irrigation system and stated that homeowners could not perform electrical, plumbing, or even air conditioning without a license.

The commission responds that homeowners that install an irrigation system on their own properties are exempt from the licensing requirements of Texas Occupations Code, §1903.002 but are not exempt from the requirements of Chapter 344, Landscape Irrigation. The commission did not make any changes to the rules as a result of these comments.

Local Authority

An individual commented that the "minimum precipitation rates", including the precipitation rate zone map, be included because some emission devices, installed with low nozzle flow rates, will meet the head to head coverage requirements but will not be able to place enough water on plant material. There are nozzle selections available from manufacturers that would allow someone to create an inefficient system. An individual stated that the minimum standards for precipitation rates should not be removed because they provide a historical benchmark. A commenter stated that irrigated sites that are larger than five acres should be audited once every three years to see if the systems are still effective and efficient in their water use. A commenter stated that the commission should require an annual inspection for irrigation systems similar to the inspection for motor vehicles. A commenter stated that meter readers could verify that inspections had been performed. A commenter stated that more stringent restrictions are needed on new irrigation systems in residential neighborhoods and that low volume/drip systems should be mandatory for flowerbeds in these situations. A commenter stated that major repairs of irrigation systems should necessitate compliance with minimum design and installation requirements. A commenter stated that inefficient water waste of existing systems should be addressed in the rules.

The commission responds that the adopted rules provide minimum standards for irrigation systems statewide and local governmental entities may adopt more stringent requirements. The commission did not make any changes to the rules as a result of these comments.

Administrative Procedure Act

An individual commented that a common source of leaks on irrigation systems is pipe breakage at the base of the sprinkler head and that mandating flexible pipe or swing joint risers below a sprinkler head in an area subject to vehicular traffic or pedestrian activity would help prevent leaks. A commenter stated that there should be rules for irrigation system operators and that in order to enhance conservation the commission should prohibit the operation of irrigation systems with broken components. An allowance for testing and repair was suggested. A commenter stated that the conversion to irrigation technician should be reconsidered and an assistantship be implemented that would provide more knowledgeable people at the job site. Another commenter recommended implementing an apprentice/journeyman program.

The commission appreciates the suggestions; however, the recommendations are outside the scope of the proposed rulemaking and including these changes at this point could be considered increasing the scope of the rules and would add costs to the irrigation system or to the irrigation system order. The Administrative Procedure Act requires that the public be given the opportunity to comment on rules that might impact them. The public was not notified in the February 1, 2008, *Texas Register* notice that the commission was considering the suggested changes. The public might have commented on any of these suggestions. The commission did not make any changes to the rules as a result of these comments.

Costs

A commenter stated that the increased cost of $350 to $580 seemed to be an arbitrary 15% increase. A commenter asked if the cost covered: maintaining records; purchasing permits; buying stickers; design software; training; increased labor costs; etc. A commenter stated that the costs would just about cover the drawing. A commenter speculated that the cost would be greater if the rules are enforced. A commenter stated that fewer rules were needed and that items that add costs or are unenforceable will hurt honest business owners and will force consumers to seek unlicensed or non-complying contractors and may ultimately discourage compliance.

The commission responds that the costs were calculated by assuming two scenarios - a low and high range. The costs for the "low range" are isolation valve and box - $14, a rain or moisture sensor - $28, a y-type strainer - $27, sticker - $1, maintenance checklist - $50, irrigation plan $210, and miscellaneous costs $20. The costs for the "high range" are isolation valve and box - $20, a rain or moisture sensor - $50, a y-type strainer - $50, sticker - $2, maintenance checklist - $85, irrigation plan $345, and miscellaneous costs $28. There will be some up-front costs associated with purchasing stickers; the cost referenced is a cost per job. Many irrigators already perform most of the requirements, so the cost should not increase significantly for items such as colored primer solvent, backflow devices, etc. Market

forces will drive the price that is being charged for irrigation systems. If there is a demand for irrigation systems, there will be legitimate irrigators who will comply with the rules. The requirement to maintain irrigation system records is consistent with the requirement for other business records. The commission did not make any changes to the rules as a result of this comment.

Some commenters stated that a customer will be charged $125 to $150 to perform the maintenance checklist items.

The commission responds that the irrigator has a business cost associated with the checklist and walk through. Homeowner education and guidance does have a cost. However, the consumer would save money on the cost of water used in irrigation and that would offset any charges that some irrigators might choose to charge customers. Lower Colorado River Authority provided comments that by operating an irrigation system twice a week, the summer outdoor water use would be decreased by 25% to 50% and would reduce peak demand on water treatment facilities. Those cost savings would be passed on to customers in the form of lower water bills. The IA's Handbook stated that a good contractor will provide full instructions on how to care for the irrigation system and how to use the mechanical components of the irrigation system. The Handbook further stated that "the contractor should know how to manage water and install an irrigation system that will provide the desired look while minimizing your use of water". Many irrigators are already providing these services to their customers. Costs can vary widely across the state depending on factors that affect the local economy. The commission did not make any changes to the rule as a result of these comments.

Some commenters stated that the additional costs were low and that the commission did not specify the water that would be saved.

The commission responds that the commenters did not provide any specific information regarding which costs were low or any alternative findings about cost. The preamble stated that if it was assumed that 25% of water used for irrigation was wasted, a homeowner, on average, could save an estimated $194 per year when an irrigation system that complies with the rules is installed. Over a five year period the estimated savings could be as much as $970. The annual water savings was assumed to be 38,000 gallons per system. Another commenter provided detailed drawings and material takeoffs with pricing. The commenter's finding is that the additional materials required as a result of the rule would cost an irrigator $166.47 and require less than one hour of additional labor. If the system conserved 25% more water and watered twice a week for ten minutes, the system would save $20 a month. The commission did not make any changes to the comment based on these comments.

A commenter stated that based on initial startup a permit would cost $1,000 because employees would have to be hired, trained, and initiate a permit processing system for irrigation. A commenter stated that the cost that had been proposed by the commission was ridiculous and the cost to the municipality for a landscape irrigation program would be high.

The commission responds that the commenter did not provide any additional information to support the claims that the cost to a municipality would be high. When the cities of El Paso and San Antonio adopted more stringent irrigation requirements several years ago, costs for irrigation systems did not increase significantly and many irrigators have installed irrigation systems that meet these requirements for years. El Paso's permitting program cost for a commercial system ranges from $80 to $120. San Antonio has proposed a new fee structure that would require an $85 annual registration fee for irrigation contractors, a $50 residential permit fee, a $100 commercial permit fee, $100 for a commercial irrigation plan review, with an allowance for charging for additional reviews, and a $50 inspection fee.

El Paso has been inspecting commercial irrigation systems for several years and has simplified the process so that the inspector has an approved irrigation plan and has knowledge of the irrigator's previous performance history. The inspection is based on a local ordinance and the International Plumbing Code 2003 (2008 will be adopted in the future).

The inspector inspects water spraying on impervious surfaces, slopes or small areas. The irrigator may be present during the inspection or if the controller is accessible, the system is turned on and inspected for overspray and for coverage, verifying that the installation is according to the approved plan.

The inspector inspects the master, isolation, or zone valve. The valve locations are shown on the approved plan and are located in valve boxes. The inspector can verify several items at one location - the depth of the incoming pipe, primer, wiring, waterproof connectors, and any additional equipment such as regulators or filters.

The inspector locates and inspects the backflow device for proper installation and use.

The inspector checks that the controller and verifies that the controller is powered and programmed.

The inspector verifies that sleeves are installed and is able to verify that primer is used in that location.

The inspector reviews the approved plan and verifies that the installation has been made in accordance with the city plan.

The inspector has the authority to ask at any time to unearth a specific area or the complete system if noncompliance is expected. El Paso has found improper piping, deleterious backfill, no primer or solvent on pipes, and improper wiring when irrigation systems were uncovered. El Paso has the ability to flag an irrigator based on past occurrences or typical code violations, such as failure to close a permit or failure to call for an inspection. Inspections often occur when the inspector is in the area which allows the inspector to view the installation as it progresses. Irrigators sometimes ask for in-progress inspections. El Paso's permitting system allows the inspector to monitor permits in various stages such as issued, inspected, or final, and plan inspections accordingly. The rules are written so that municipalities and water districts have the ability to implement the landscape irrigation program in an efficient manner, such as phasing-in requirements or conducting more thorough reviews or inspections on higher risk projects. Municipalities and water districts may choose to contract elements of the program to avoid an initial up-front cost. A commercial irrigation system permit in El Paso usually costs $80 to $120. The cost is calculated using a base rate and then a per item or per measurement fee. The commenter did not provide any information to support the claim that a permit would cost $1,000. The commission did not make any changes to the rules based on these comments.

A commenter stated that the fiscal note stated that a controller could be replaced for $50 to $100 and stated a cost savings of $30 to $50 every time the controller is interrupted, then it should be required because it would conserve water.

The commission responds that §344.62(i) requires the installation of sensors or other technology designated to inhibit or interrupt irrigation system operation during periods of moisture or rainfall when replacing an existing automatic controller. The example in the fiscal note is that of a very large commercial irrigation system that would have automatic controllers and inhibiting devices that could save the entity $30 to $50 per interrupted water schedule. These savings are not representative of a small residential system. The commission did not make any changes to the rules as a result of this comment.

Enforcement

Numerous commenters stated that enforcement of irrigation rules should be a priority. Commenters stated that the current rules should be enforced. A commenter stated that every irrigator wanted a true enforcement program. A commenter requested an analysis of state rules to identify if there is an alternate place in the Texas Administrative Code where rules can be developed that will provide meaningful consequences for individuals practicing without a license. Numerous commenters stated the commission should respond to complaints more timely and with more serious consequences.

The commission responds that these comments are beyond the scope of the Chapter 344 rulemaking. The commission's enforcement's actions are governed by 30 TAC Chapter 70 and the commission's Enforcement Initiation Criteria, and the Penalty Policy. There is no federal standard for landscape irrigation programs. The commission has and continues to pursue enforcement actions against licensed and unlicensed individuals that do not follow landscape irrigation rules. Many irrigation system owners have been reluctant to provide documentation that would prove that an unlicensed person installed their irrigation system. Most of the enforcement actions taken by the state are administrative in nature and in some instances include a minimum penalty. Cities and water districts that adopt landscape irrigation programs will greatly enhance the ability to pursue rules and violations. The commission did not make any changes to the rules as a result of these comments.

Other comments

A commenter asked TCEQ to "fully" clarify all changes to the rules in an effort to eliminate any loopholes in the system.

The commission responds that the purpose of the preamble is to fully clarify all changes. The commission did not make any changes to the rules as a result of these comments.

Several commenters stated the rules lacked verbiage to be enforceable and that rules should be easy to verify and fairly enforced.

The commission responds the adopted rules improve on the existing rules and provide better clarity and improves enforcement. The rules clearly state the minimum performance expectations for landscape irrigation systems in Texas and clearly define the duties and responsibilities of irrigators, installers, irrigation technicians, and irrigation inspectors. Trained inspectors will be able to take appropriate actions to make sure irrigation systems are designed and installed in a manner that will conserve water. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that the Chapter 344 rules revisions had little to do with water conservation.

The commission responds that the rules adopted comply with the requirements of HB 4/SB 3 that are intended to increase water conservation. The rules address the design, installation, and operation of irrigation systems, water conservation, the duties and responsibilities of irrigators. The rules also address the requirement that municipalities with a population of 20,000 must adopt a landscape irrigation program and provide a new license type, irrigation inspector. The rules as adopted and their implementation will conserve water. The commission did not make any changes to the rules as a result of this comment.

Several commenters stated that illegal installers will be able to charge homeowners less for an irrigation system and that small firms could not compete with unlicensed firms or individuals who would not follow the rules. Other commenters stated that there will be fewer legitimate irrigators. Some commenters stated that the rules provide a disadvantage to small businesses. Some commenters stated that the cost of irrigation systems will increase. Some commenters stated that the small business and micro-business assessment contained in the preamble underestimated the impact on small and micro businesses.

The commission responds that San Antonio has adopted many of the requirements that have been adopted in Chapter 344, and has found that the number of illegal and poor installations has decreased and that as a result, business for good installations has increased. In San Antonio the price that "good" irrigators charged did not change significantly but the price of marginal irrigation systems did increase. All businesses that perform irrigation work will have to comply with the adopted rules. The commenters did not provide any additional cost information to support the claims. The commission did not make any changes to the rules as a result of these comments.

IA commented that efficiency should be developed on an individual site basis to keep enforcement practical.

The commission responds that governmental entities that implement landscape irrigation programs may develop criteria for water conservation. Local entities have the authority to enforce rules or ordinances that address excess water usage. Implementing a system on a statewide basis that includes many areas that are not required to implement and enforce landscape irrigation programs would be difficult to enforce. The commission did not make any changes to the rules as a result of this comment.

Some commenters stated that irrigation systems could be turned off without affecting the health of the public because inadequate systems could be turned off.

The commission responds that in many municipalities and water districts, inadequate irrigation systems are not being turned off because turning off the water to the irrigation system also turns off the water to the residence or commercial building. The inclusion of an isolation valve on new irrigation systems will allow owners or government officials to turn off malfunctioning or inadequate irrigation systems. The commission did not make any changes to the rules as a result of this comment.

Some commenters stated that the irrigator could be brought to account for an inadequate installation and civil law can be used to recover damages and/or require changes.

The commission responds that HB 4/SB 3 require the commission to adopt rules that address the design, installation, and operation of irrigation systems; water conservation; and the duties and responsibilities of licensed irrigators. The adopted rules ad-

dress those requirements. The commission did not make any changes to the rule as a result of these comments.

A commenter stated that the commission should be held accountable that the rules have been thoroughly reviewed and that licensed irrigators will be held accountable for complying with the rules.

The commission responds that the rules have been thoroughly reviewed and are enforceable. Local governmental entities and the state will hold licensed irrigators accountable for following state and local rules or ordinances. The commission did not make any changes to the rules as a result of this comment.

A commenter stated that TCEQ should prepare an example form for the information required in the rules change. A commenter asked that a hypothetical example, or mock contract, be provided to show the contractual requirements in §344.71(c).

The commission responds that TCEQ is planning to update the Landscape Irrigation webpage with a Frequently Asked Questions section for use by irrigators, homeowners, and exempt businesses. A Regulatory Guidance Document is also being planned that would provide example forms and language for use by irrigators. The commission did not make any changes to the rules as a result of these comments.

Several commenters questioned asked how much water would be saved by the rules; specifically, how much will be saved by the as-built plan, the maintenance checklist, seasonally adjusted ET schedule, and the three minute flow test.

The commission responds that an estimated water savings for the as built plan, the maintenance checklist, the seasonally adjusted ET schedule, and the three-minute flow test has not been calculated. The zone flow measurement test has been modified in §344.1(45) as a result of this comment. The requirements relate to operating a more efficient irrigation system, and any savings will be based on the irrigator or irrigation technician providing information to the irrigation system owner or owner's representative during the walk through. The information will explain the irrigation system operation and maintenance and provide details to adjust the controller to reflect the seasonal watering requirements in Texas. Both can lead to more efficient system operation. The as-built plan will allow repairs to be made more quickly, allow the homeowner to replace emission devices or other parts with the same type of component, and thus help insure the integrity of the irrigation system. These items will ultimately operate to conserve water. The commission made changes to §344.1(45) has been changed in response to the comment.

A commenter stated that the rules do not promote water conservation but they would result in a defined, uniform method of irrigation installation in Texas.

The commission responds that overall the rules do promote water conservation. The various design and installation requirements coupled with improved contractual and warranty requirements will encourage irrigation system owners to have repairs made in a more timely fashion. The information provided to irrigation system owners will help promote efficient irrigation system operation. The commission did not make any changes to the rules as a result of this comment.

Some commenters stated the state was micro managing.

The commission responds that HB 4/SB 3 require the commission to adopt rules that address the design, installation, and operation of irrigation systems, water conservation, and the duties and responsibilities of licensed irrigators. The commission did not make any changes to the rules as a result of this comment.

A commenter stated that some commercial property owners asked to have irrigation systems installed without proper design and backflow devices which does not meet state mandates.

The commission responds that the current rules have requirements for a design and backflow device. The new rules have given more specificity to the requirements of the design and are consistent with the Public Drinking Water rules. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that many of the rules and regulations are restrictions of free trade and commerce as governed by the Uniform Commercial Code.

These rules are based on clearly articulated and expressed state legislative policy to regulate landscape irrigation in the state of Texas. HB 4/SB 3 directed the commission to adopt rules that govern: (1) the connection of an irrigation system to any water supply; (2) the design, installation, and operation of irrigation systems; (3) water conservation; and (4) the duties and responsibilities of irrigators. HB 1656 adds a new landscape irrigation license classification, irrigation inspector, and directs municipalities with populations of 20,000 or more to adopt ordinances that require irrigation inspectors be licensed by the commission and that irrigators obtain a permit before installing an irrigation system. Municipalities must adopt standards and specifications for designing, installing, and operating irrigation systems and include any rules adopted by the agency that are related to landscape irrigation. As required by HB 4 §19 and SB 3, the commission must adopt standards no later than June 1, 2008, with an effective date of January 1, 2009. The landscape irrigation program is actively monitored and supervised by the state through the TCEQ's Landscape Irrigation program. The commission did not make any changes to the rules as a result of this comment.

A commenter stated that the proposed changes needed more input from irrigators.

The commission responds that there was a significant notice of the proposed rule and a 30-day comment period allows for public comment on rules. The commission published the proposed rules on the agency's web site in December 2007. The proposed rules were published in the *Texas Register* on February 1, 2008. The Texas Turf and Irrigation Association (TTIA) home page published a notice about the proposal. TTIA also sent post cards to all members notifying them of the proposed rules, public hearing date, and comment period. The IA sent an e-mail to all Texas members related to the rules. Austin Lawn and Sprinkler Association sent an e-mail to 59 people informing them of the public hearing on the Chapter 344 rules. A public hearing was held on February 26, 2008. All of these efforts were directed to encourage input from irrigators and other interested parties. In addition, during a multi-week period two Irrigator Advisory Council members visited over ten cities around the state to obtain local input from local associations and irrigators. A stakeholders meeting was held in Austin on August 10, 2007. Written comments were accepted prior to and after the meeting. The commission did not make any changes to the rules as a result of this comment.

A commenter stated that the rules go on and on and try to keep irrigators busy with paperwork and that the rules should be more user friendly. A commenter stated that the commission continued inept governance over the irrigation industry and that the

commission thinks that more rules and oversight is the answer to everything. Another commenter stated that business owners have to multi-task and that should be considered in adopting any rules. Another commenter stated that the rules would waste man hours and create unneeded paperwork and would force some irrigators out of business. A commenter stated that changes should be made so that it would not negatively impact 90% of the contractors. A commenter stated that some of the rules proposed were wrong.

The commission responds that the commenters did not provide information to support the general claims. The commission was directed by HB 4/SB 3 to adopt rules that address the design, installation and operation or irrigation systems, water conservation, and the duties and responsibilities of irrigators. The commission created a new irrigation technician license with expanded responsibilities that will greatly assist the irrigator in complying with these rules. San Antonio implemented a program that includes many of the requirements that have been adopted in Chapter 344. San Antonio found that the number of illegal and poor installations has decreased. The adopted rules balance the needs of the irrigator to multi-task and earn money, with the need to implement business practices to support water conservation, to provide information that will educate irrigation system owners about the importance of water conservation when using their irrigation system and maintain business records. The commission did not make any changes to the rules as a result of these comments.

A commenter questioned why the Backflow Prevention Assembly Tester (BPAT) licensees were not required to have rubber stamps.

The commission responds that the BPAT requirements were not considered as part of the rulemaking for landscape irrigation. The suggestion was forwarded to the appropriate staff for consideration. The commission did not make any changes to the rules as a result of this comment.

A commenter stated that most of the rules were not new but were already on the books.

The commission agrees. The rules were reorganized, so rules that were already on the books had to be repealed and the existing (reorganized) and new (added) rules proposed for public comment. The adopted rules are a mix of old and new rules. The commission did not make any changes to the rules as a result of this comment.

Some commenters stated that regulations do not conserve water.

The commission responds that no single element of the rule, by itself, accomplishes water conservation, but it is the combination of various elements of the adopted rules that will accomplish this objective. The emphasis on proper design, installation, application of components, warranties, new irrigation licenses, homeowner education, etc. all contribute toward achieving the goal of HB 4/SB 3 which is ultimately to conserve water for current and future generations. The commission did not make any changes to the rules as a result of this comment.

A commenter stated that IA's 1990 Water Conservation Policy emphasized economic incentives and that SB 3 clearly defines BMPs as voluntary.

The commission responds that several sources of information were considered in the rules including, the IA's BMPs (2005) related to design, pressure regulation, technology, installation and water conservation; IA's consumer information (www.irrigation.org/Rsrcs); and IA's materials used for design training. Ordinances, rules and irrigation system information from Texas, Colorado, California, Minnesota, Oregon and Florida were reviewed. The EPA's WaterSense program was considered. Basic irrigation textbooks used in Texas were consulted. The references to voluntary BMPs in HB 4/SB 3 are not directly related to irrigation, but to the Water Resource Council's duties and responsibilities in reviewing new technology related to water conservation. HB 4/SB 3 directed the commission to adopt rules that irrigation systems be designed, installed, maintained, repaired, and serviced in a manner that would promote water conservation. HB 4/SB 3 also directed the commission to adopt rules related to an irrigator's duties and responsibilities. The commission did not make any changes to the rules as a result of these comments.

A commenter supported the repeal of Chapter 344 in its entirety with replacement of new language but did not provide any proposed changes to Subchapter B, Standard of Conduct and Subchapter H, Irrigator Advisory Council. A commenter supported retaining, not repealing, Subchapter D (§§344.70 - 344.73, 344.75 and 344.77).

The commission responds that HB 1656 requires municipalities of 20,000 or more to adopt landscape irrigation programs thus the language in §344.70 and §344.71 is no longer applicable. HB 4/SB 3 directed the commission to adopt rules related to water conservation, thus the repeal of §344.72, which only generally addressed water conservation. The adopted rules provide specific requirements to promote water conservation. Section 344.73 addressed backflow prevention methods and §344.75 addressed cross-connections. The adopted rules provide additional and updated information concerning backflow and cross connections. Section 344.77 contained outdated minimum design and installation standards. The adopted rule addresses new technology and standards. The commission did not make changes to the rules based on these comments.

Some commenters stated that irrigation was not as important as plumbing but the irrigator and technician seem to be equated to a Master and Journeyman plumber and that the requirement to be on-site indicates an importance of the irrigator or technician that should not be required since irrigation does not rise to the importance of potable water plumbing.

The commission responds that HB 4, SB 3, and HB 1656 directed the commission to address the standards for the design, installation, and operation of irrigation systems, water conservation, and the duties and responsibilities of irrigators. The adopted rules address standards for design, installation, and operation of irrigation systems and provide more efficient irrigation systems. In addition to water conservation, an irrigation system could subject the water supply to potential contamination if proper controls are not installed. Since irrigation systems can waste water and there is potential contamination of the public water supply from an irrigation system, it is important to have either a trained and licensed irrigator or irrigation technician on-site at all times. There were no changes to the rules as a result of these comments.

Some commenters stated that builders and large contractors do not always abide by any rules and that builders should be educated. Other commenters stated that the commission should undertake an education effort. Some commenters stated that many people think it is acceptable to hire their lawn maintenance company to repair their sprinkler system. Other commenters stated

that site designers and landscape architects should be held responsible for the design of landscape irrigation systems.

The commission responds that upon adoption of the rules, the commission will initiate an education program that will target irrigation system owners, irrigators, home builders, and exempt businesses to stress the importance of following all landscape irrigation program rules. The commission will update the website to include a Frequently Asked Questions section for irrigation system owners, irrigators and exempt businesses. The commission will develop brochures to communicate the importance of landscape irrigation. The commission will inform exempt business organizations of the adopted rules and ask their assistance in informing members that the design, installation and operation standards apply to everyone. The commission did not make any changes to the rules as a result of these comments.

A commenter stated that the rules should set minimum standards not methods, process, or equipment because those rules would be flawed.

The commission responds that the adopted rules set minimum standards for the performance of irrigation activities. The rules were adopted in compliance with HB 4/SB 3. The adopted rules build upon rules that have been in place for a number of years but have been updated to reflect new technology. The commission did not make any changes to the rules as a result of this statement.

IA commented that the increased cost of the irrigation system relate to process and administrative expense with no established metrics to measure the effectiveness of the mandates. IA stated that the citizens of Texas should receive tangible data as a reassurance that the added cost results in increased landscape irrigation efficiency. IA suggested a shift in focus on outcome.

The commission responds that the citizens of Texas will receive an enhanced guarantee of available water resources during their lifetime. If an efficient irrigation system can reduce water consumption by 25% over the 20 year usable lifespan, the system can potentially save over 0.75 million gallons of water. The increased costs are related to the requirement to install an isolation valve and box, a rain/moisture sensor or other technology, a y-type strainer, stickers, providing a maintenance checklist, putting the design on paper and other miscellaneous costs. A shift in focus to outcome measurements would, in fact, increase the cost of the irrigation system to the irrigation system owner since additional measurement equipment (such as a water meter or flow meter) would need to be installed. Governmental entities would be responsible for gathering, analyzing and providing the data to irrigation system owners which would be an additional cost. The commission did not make any changes to the rules as a result of these comments.

SUBCHAPTER A. GENERAL PROVISIONS

30 TAC §344.1, §344.4

STATUTORY AUTHORITY

These repeals are adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; TWC, §5.105, concerning General Policy; and TWC, §5.107, concerning Advisory Committees, Work Groups, and Task Forces. These repeals are also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. These repeals are also adopted under Texas Occupations Code (TOC), §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; TOC, §1903.151, concerning Council Membership; TOC, §1903.152, concerning Eligibility of Public Members; TOC, §1903.155, concerning Presiding Officer; TOC, §1903.157, concerning Meetings; TOC, §1903.158, concerning Per Diem Reimbursement; TOC, §1903.159, concerning Council Duties; and TOC, §1903.251, concerning License Required. Finally, these repeals are also adopted under Texas Health and Safety Code (THSC), §341.033, concerning Protection of Public Water Supplies; and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

These adopted repeals implement TWC, §§5.013, 5.102, 5.103, 5.105, 5.107, and 37.001 - 37.015; TOC, §§1903.001, 1903.002, 1903.053, 1903.151, 1903.152, 1903.155, 1903.157, 1903.158, 1903.159, and 1903.251; THSC, §341.033 and §341.034.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803455
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER B. GENERAL PROVISIONS AFFECTING THE IRRIGATOR ADVISORY COUNCIL

30 TAC §344.10

STATUTORY AUTHORITY

This repeal is adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; TWC, §5.105, concerning General Policy; and TWC, §5.107, concerning Advisory Committees, Work Groups, and Task Forces. This repeal is also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. This repeal is also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; TOC, §1903.151, concerning Council Membership; TOC, §1903.152, concerning Eligibility of Public Members; TOC, §1903.155, concerning Presiding Officer; TOC, §1903.157, concerning Meetings; TOC, §1903.158, concerning Per Diem

Reimbursement; TOC, §1903.159, concerning Council Duties; and TOC, §1903.251, concerning License Required. Finally, this repeal is also adopted under THSC, §341.033, concerning Protection of Public Water Supplies and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

The adopted repeal implements TWC, §§5.013, 5.102, 5.103, 5.105, 5.107, and 37.001 - 37.015; TOC, §§1903.001, 1903.002, 1903.053, 1903.151, 1903.152, 1903.155, 1903.157, 1903.158, 1903.159, and 1903.251; THSC, §341.033 and §341.034.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803456
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER C. REQUIREMENTS FOR LICENSED IRRIGATORS AND LICENSED INSTALLERS

30 TAC §§344.49, 344.58 - 344.63

STATUTORY AUTHORITY

These repeals are adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; and TWC, §5.105, concerning General Policy. These repeals are also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. These repeals are also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; and TOC, §1903.251, concerning License Required. Finally, these repeals are also adopted under THSC, §341.033, concerning Protection of Public Water Supplies; and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

These adopted repeals implement TWC, §§5.013, 5.102, 5.103, 5.105, and 37.001 - 37.015; TOC, §§1903.001, 1903.002, 1903.053, and 1903.251; and THSC, §341.033 and §341.034.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803457
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER D. STANDARDS FOR LANDSCAPE IRRIGATION

30 TAC §§344.70 - 344.73, 344.75, 344.77

STATUTORY AUTHORITY

These repeals are adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; and TWC, §5.105, concerning General Policy. These repeals are also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. These repeals are also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; and TOC, §1903.251, concerning License Required. Finally, these repeals are also adopted under THSC, §341.033, concerning Protection of Public Water Supplies and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

These adopted repeals implement TWC, §§5.013, 5.102, 5.103, 5.105, and 37.001 - 37.015; TOC, §§1903.001, 1903.002, 1903.053, and 1903.251; and THSC, §341.033 and §341.034.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803458
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER F. STANDARDS OF CONDUCT FOR LICENSED IRRIGATORS AND INSTALLERS

30 TAC §§344.90 - 344.96

STATUTORY AUTHORITY

These repeals are adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103,

concerning Rules; and TWC, §5.105, concerning General Policy. These repeals are also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. These repeals are also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; and TOC, §1903.251, concerning License Required. Finally, these repeals are also adopted under THSC, §341.033, concerning Protection of Public Water Supplies and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

These adopted repeals implement TWC, §§5.013, 5.102, 5.103, 5.105, and 37.001 - 37.015; TOC, §§1903.001, 1903.002, 1903.053, and 1903.251; and THSC, §341.033 and §341.034.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803459
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER A. DEFINITIONS

30 TAC §344.1

STATUTORY AUTHORITY

This new section is adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; TWC, §5.105, concerning General Policy; and TWC, §5.107, concerning Advisory Committees, Work Groups, and Task Forces. This new section is also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. This new section is also adopted under TWC, §49.238, concerning Irrigation Systems. This new section is also adopted under Local Government Code, §401.006, concerning Irrigation Systems. This new section is also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; TOC, §1903.151 concerning Council Membership; TOC, §1903.152, concerning Eligibility of Public Members; TOC, §1903.155, concerning Presiding Officer; TOC, §1903.157, concerning Meetings; TOC, §1903.158 concerning Per Diem Reimbursement; TOC, §1903.159, concerning Council Duties; and TOC, §1903.251, concerning License Required. This new section is also adopted under THSC, §341.033, concerning Protection of Public Water Supplies; and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

This adopted new section implements TWC, §§5.013, 5.102, 5.103, 5.105, 5.107, 37.001 - 37.015, and 49.238; Local Government Code, §401.006; TOC, §§1903.001, 1903.002, 1903.053, 1903.151, 1903.152, 1903.155, 1903.157, 1903.158, 1903.159, and 1903.251; THSC, §341.033 and §341.034.

§344.1. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Air gap--A complete physical separation between the free flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel.

(2) Atmospheric Vacuum Breaker--An assembly containing an air inlet valve, a check seat, and an air inlet port. The flow of water into the body causes the air inlet valve to close the air inlet port. When the flow of water stops the air inlet valve falls and forms a check against back-siphonage. At the same time it opens the air inlet port allowing air to enter and satisfy the vacuum. Also known as an Atmospheric Vacuum Breaker Back-siphonage Prevention Assembly.

(3) Backflow prevention--The mechanical prevention of reverse flow, or back siphonage, of nonpotable water from an irrigation system into the potable water source.

(4) Backflow prevention assembly--Any assembly used to prevent backflow into a potable water system. The type of assembly used is based on the existing or potential degree of health hazard and backflow condition.

(5) Completion of irrigation system installation--When the landscape irrigation system has been installed, all minimum standards met, all tests performed, and the irrigator is satisfied that the system is operating correctly.

(6) Consulting--The act of providing advice, guidance, review or recommendations related to landscape irrigation systems.

(7) Cross-connection--An actual or potential connection between a potable water source and an irrigation system that may contain contaminates or pollutants or any source of water that has been treated to a lesser degree in the treatment process.

(8) Design--The act of determining the various elements of a landscape irrigation system that will include, but not limited to, elements such as collecting site specific information, defining the scope of the project, defining plant watering needs, selecting and laying out emission devices, locating system components, conducting hydraulics calculations, identifying any local regulatory requirements, or scheduling irrigation work at a site. Completion of the various components will result in an irrigation plan.

(9) Design pressure--The pressure that is required for an emission device to operate properly. Design pressure is calculated by adding the operating pressure necessary at an emission device to the total of all pressure losses accumulated from an emission device to the water source.

(10) Double Check Valve--An assembly that is composed of two independently acting, approved check valves, including tightly closed resilient seated shutoff valves attached at each end of the assembly and fitted with properly located resilient seated test cocks. Also known as a Double Check Valve Backflow Prevention Assembly.

(11) Emission device--Any device that is contained within an irrigation system and that is used to apply water. Common emission devices in an irrigation system include, but are not limited to, spray and rotary sprinkler heads, and drip irrigation emitters.

(12) Employed--Engaged or hired to provide consulting services or perform any activity relating to the sale, design, installation, maintenance, alteration, repair, or service to irrigation systems. A person is employed if that person is in an employer-employee relationship as defined by Internal Revenue Code, 26 United States Code Service, §3212(d) based on the behavioral control, financial control, and the type of relationship involved in performing employment related tasks.

(13) Head-to-head spacing--The spacing of spray or rotary heads equal to the manufacturer's published radius of the head.

(14) Health hazard--A cross-connection or potential cross-connection with an irrigation system that involves any substance that may, if introduced into the potable water supply, cause death or illness, spread disease, or have a high probability of causing such effects.

(15) Hydraulics--The science of dynamic and static water; the mathematical computation of determining pressure losses and pressure requirements of an irrigation system.

(16) Inspector--A licensed plumbing inspector, water district operator, other governmental entity, or irrigation inspector who inspects irrigation systems and performs other enforcement duties for a municipality or water district as an employee or as a contractor.

(17) Installer--A person who actually connects an irrigation system to a private or public raw or potable water supply system or any water supply, who is licensed according to Chapter 30 of this title (relating to Occupational Licenses and Registrations).

(18) Irrigation inspector--A person who inspects irrigation systems and performs other enforcement duties for a municipality or water district as an employee or as a contractor and is required to be licensed under Chapter 30 of this title (relating to Occupational Licenses and Registrations).

(19) Irrigation plan--A scaled drawing of a landscape irrigation system which lists required information, the scope of the project, and represents the changes made in the installation of the irrigation system.

(20) Irrigation services--Selling, designing, installing, maintaining, altering, repairing, servicing, permitting, providing consulting services regarding, or connecting an irrigation system to a water supply.

(21) Irrigation system--An assembly of component parts that is permanently installed for the controlled distribution and conservation of water to irrigate any type of landscape vegetation in any location, and/or to reduce dust or control erosion. This term does not include a system that is used on or by an agricultural operation as defined by Texas Agricultural Code, §251.002.

(22) Irrigation technician--A person who works under the supervision of a licensed irrigator to install, maintain, alter, repair, service or supervise installation of an irrigation system, including the connection of such system in or to a private or public, raw or potable water supply system or any water supply, and who is required to be licensed under Chapter 30 of this title (relating to Occupational Licenses and Registrations).

(23) Irrigation zone--A subdivision of an irrigation system with a matched precipitation rate based on plant material type (such as turf, shrubs, or trees), microclimate factors (such as sun/shade ratio), topographic features (such as slope) and soil conditions (such as sand, loam, clay, or combination) or for hydrological control.

(24) Irrigator--A person who sells, designs, offers consultations regarding, installs, maintains, alters, repairs, services or supervises the installation of an irrigation system, including the connection of such system to a private or public, raw or potable water supply system or any water supply, and who is required to be licensed under Chapter 30 of this title (relating to Occupational Licenses and Registrations).

(25) Irrigator-in-Charge--The irrigator responsible for all irrigation work performed by an exempt business owner, including, but not limited to obtaining permits, developing design plans, supervising the work of other irrigators or irrigation technicians, and installing, selling, maintaining, altering, repairing, or servicing a landscape irrigation system.

(26) Landscape irrigation--The science of applying the necessary amount of water to promote or sustain healthy growth of plant material or turf.

(27) License--An occupational license that is issued by the commission under Chapter 30 of this title to an individual that authorizes the individual to engage in an activity that is covered by this chapter.

(28) Mainline--A pipe within an irrigation system that delivers water from the water source to the individual zone valves.

(29) Maintenance checklist--A document made available to the irrigation system's owner or owner's representative that contains information regarding the operation and maintenance of the irrigation system, including, but not limited to: checking and repairing the irrigation system, setting the automatic controller, checking the rain or moisture sensor, cleaning filters, pruning grass and plants away from irrigation emitters, using and operating the irrigation system, the precipitation rates of each irrigation zone within the system, any water conservation measures currently in effect from the water purveyor, the name of the water purveyor, a suggested seasonal or monthly watering schedule based on current evapotranspiration data for the geographic region, and the minimum water requirements for the plant material in each zone based on the soil type and plant material where the system is installed.

(30) Major maintenance, alteration, repair, or service--Any activity that involves opening to the atmosphere the irrigation main line at any point prior to the discharge side of any irrigation zone control valve. This includes, but is not limited to, repairing or connecting into a main supply pipe, replacing a zone control valve, or repairing a zone control valve in a manner that opens the system to the atmosphere.

(31) Master valve--A remote control valve located after the backflow prevention device that controls the flow of water to the irrigation system mainline.

(32) Matched precipitation rate--The condition in which all sprinkler heads within an irrigation zone apply water at the same rate

(33) New installation--An irrigation system installed at a location where one did not previously exist.

(34) Non-health hazard--A cross-connection or potential cross connection from a landscape irrigation system that involves any substance that generally would not be a health hazard but would constitute a nuisance or be aesthetically objectionable if introduced into the potable water supply.

(35) Non-potable water--Water that is not suitable for human consumption. Non-potable water sources include, but are not limited to, irrigation systems, lakes, ponds, streams, gray water that is dis-

charged from washing machines, dishwashers or other appliances, water vapor condensate from cooling towers, reclaimed water, and harvested rainwater.

(36) Pass-through contract--A written contract between a contractor or builder and a licensed irrigator or exempt business owner to perform part or all of the irrigation services relating to an irrigation system.

(37) Potable water--Water that is suitable for human consumption.

(38) Pressure Vacuum Breaker--An assembly containing an independently operating internally loaded check valve and an independently operating loaded air inlet valve located on the discharge side of the check valve. Also known as a Pressure Vacuum Breaker Back-siphonage Prevention Assembly.

(39) Reclaimed water--Domestic or municipal wastewater which has been treated to a quality suitable for beneficial use, such as landscape irrigation.

(40) Records of landscape irrigation activities--The irrigation plans, contracts, warranty information, invoices, copies of permits, and other documents that relate to the installation, maintenance, alteration, repair, or service of a landscape irrigation system.

(41) Reduced Pressure Principle Backflow Prevention Assembly--An assembly containing two independently acting approved check valves together with a hydraulically operating mechanically independent pressure differential relief valve located between the two check valves and below the first check valve.

(42) Static water pressure--The pressure of water when it is not moving.

(43) Supervision--The on-the-job oversight and direction by a licensed irrigator who is fulfilling his or her professional responsibility to the client and/or employer in compliance with local or state requirements. Also a licensed installer working under the direction of a licensed irrigator or beginning January 1, 2009, an irrigation technician who is working under the direction of a licensed irrigator to install, maintain, alter, repair or service an irrigation system.

(44) Water conservation--The design, installation, service, and operation of an irrigation system in a manner that prevents the waste of water, promotes the most efficient use of water, and applies the least amount of water that is required to maintain healthy individual plant material or turf, reduce dust, and control erosion.

(45) Zone flow--A measurement, in gallons per minute or gallons per hour, of the actual flow of water through a zone valve, calculated by individually opening each zone valve and obtaining a valid reading after the pressure has stabilized. For design purposes, the zone flow is the total flow of all nozzles in the zone at a specific pressure.

(46) Zone valve--An automatic valve that controls a single zone of a landscape irrigation system.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803460

Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER B. STANDARDS OF CONDUCT FOR IRRIGATORS, INSTALLERS, IRRIGATION TECHNICIANS, AND IRRIGATION INSPECTORS, AND LOCAL REQUIREMENTS

30 TAC §§344.20 - 344.24

STATUTORY AUTHORITY

These new sections are adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; and TWC, §5.105, concerning General Policy. These new sections are also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. These new sections are also adopted under TWC, §49.238, concerning Irrigation Systems. These new sections are also adopted under Local Government Code, §401.006, concerning Irrigation Systems. These new sections are also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; and TOC, §1903.251, concerning License Required. Finally, these new sections are also adopted under THSC, §341.033, concerning Protection of Public Water Supplies; and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

These adopted new sections implement TWC, §§5.013, 5.102, 5.103, 5.105, 37.001 - 37.015, and 49.238; Local Government Code, §401.006; TOC, §§1903.001, 1903.002, 1903.053, and 1903.251; THSC, §341.033 and §341.034.

§344.24. Local Regulation and Inspection.

(a) Where any city, town, county, special purpose district, other political subdivision of the state, or public water supplier requires licensed irrigators, installers, irrigation technicians, or irrigation inspectors to comply with reasonable inspection requirements, ordinances, or regulations designed to protect the public water supply, any of which relates to work performed or to be performed within such political subdivision's territory the licensed irrigator, installer, irrigation technician, or irrigation inspector must comply with such requirements, ordinances, and regulations.

(b) Any city, town, county, other political subdivision of the state, or public water supplier that is not required to adopt rules or ordinances regulating landscape irrigation may adopt a landscape irrigation program by ordinance or rule and may be responsible for inspection of connections to its public water supply system up to and including the backflow prevention device.

(c) Municipalities with a population of 20,000 or more and a water district that chooses to implement a landscape irrigation program must verify that the irrigator that designs and installs an irrigation system holds a valid irrigator's license and has obtained a permit before installing a system within its territorial limits or if a municipality, its extraterritorial jurisdiction. Inspectors must verify that the design and installation meet the requirements of this chapter and local ordinances or rules that do not conflict with this chapter, or that are more stringent than this chapter.

(d) Each inspector shall maintain a log of all irrigation systems inspected that includes, but is not limited to, the system location, property owner, irrigator responsible for installation, permit status, problems noted during the inspection, and date of the inspection. The log must be kept for three years. The log shall be available for review within two business days of the request by authorized representatives of the commission or any regulatory authority with jurisdiction over landscape irrigation issues in the area the inspector is employed to inspect.

(e) An inspector may not inspect a landscape irrigation system that is an on-site sewage disposal system, as defined by Texas Health and Safety Code, §366.002.

(f) An inspector may not inspect an irrigation system that is used on or by an agricultural operation as defined by Texas Agricultural Code, §251.002; or is connected to a groundwater well that is used by the property owner for domestic use.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803461
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER C. REQUIREMENTS FOR LICENSED IRRIGATORS, INSTALLERS, IRRIGATION TECHNICIANS, AND IRRIGATION INSPECTORS

30 TAC §§344.30 - 344.38

STATUTORY AUTHORITY

These new sections are adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; and TWC, §5.105, concerning General Policy. These new sections are also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. These new sections are also adopted under TWC, 49.238, concerning Irrigation Systems. These new sections are also adopted under Local Government Code, §401.006, concerning Irrigation Systems. These new sections are also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; and TOC, §1903.251, concerning License Required. Finally, these new sections are also adopted under THSC, §341.033, concerning Protection of Public Water Supplies; and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

These adopted new sections implement TWC, §§5.013, 5.102, 5.103, 5.105, 37.001 - 37.015, and 49.238; Local Government Code, §401.006; TOC, §§1903.001, 1903.002, 1903.053, and 1903.251; and THSC, §341.033 and §341.034.

§344.30. License Required.

(a) An irrigator is an individual who:

(1) sells, designs, provides consultation services, installs, maintains, alters, repairs, or services an irrigation system, including the connection of such system to any water supply;

(2) advertises or represents to anyone that the individual can perform any or all of these functions; and

(3) is required to hold a valid irrigator license issued under Chapter 30 of this title (relating to Occupational Licenses and Registrations).

(b) Through December 31, 2009, an installer is an individual who connects an irrigation system to any water supply.

(c) Beginning January 1, 2009, an irrigation technician is an individual who:

(1) connects an irrigation system to a water supply;

(2) under the supervision of a licensed irrigator, installs, maintains, alters, repairs, or services a landscape irrigation system;

(3) represents to anyone that the individual can perform any or all of these functions; and

(4) is required to hold a valid irrigation technician license issued under Chapter 30 of this title.

(d) All irrigators, installers, and irrigation technicians shall comply with the rules contained in this chapter when performing any or all of the functions listed in this section.

(e) An individual who inspects irrigation systems and enforces a municipality's landscape irrigation ordinance must:

(1) hold a valid irrigation inspector license issued according to Chapter 30 of this title; or

(2) hold a valid plumbing inspector license.

(f) An individual who inspects irrigation systems and enforces a water district's rules related to landscape irrigation systems must:

(1) hold a valid irrigation inspector license issued according to Chapter 30 of this title;

(2) hold a valid plumbing inspector license;

(3) be the district's operator; or

(4) be another regulatory authority with jurisdiction over landscape irrigation.

(g) An inspector shall comply with the rules contained in this chapter when performing any or all of the functions listed in this section.

(h) A property owner is not required to be licensed in accordance with Texas Occupations Code, Title 12, §1903.002(c)(1) if he or she is performing irrigation work in a building or on a premises owned or occupied by the person as the person's home. A home or property owner who installs an irrigation system must meet the standards contained in §344.62(b) Spacing, §344.62(c) Water pressure, §344.62(g) related to spraying water over impervious materials, §344.62(j) Rain or moisture shut-off devices or other technology, and §344.62(k) Isolation valve. Municipalities or water districts may adopt more stringent requirements for a home or property owner who installs an irrigation system.

§344.34. Use of License.

(a) No one other than the irrigator, installer, irrigation technician, or irrigation inspector to whom a license is issued shall use or attempt to use the license, which includes the license number.

(b) An individual who uses or attempts to use the license or license number of someone else who is a licensed irrigator, licensed installer, licensed irrigation technician, or licensed irrigation inspector is in violation of Texas Occupations Code, Chapter 1903, and this chapter.

(c) An irrigator's license or license number may be used at only one entity as the irrigator-in-charge. An irrigator may work for other entities, but not as the irrigator-in-charge.

(d) It is a violation of this chapter for an irrigator, installer, irrigation technician or irrigation inspector to authorize or allow another person or entity to use the irrigator's, installer's, irrigation technician's, or irrigation inspector's license or license number in a manner inconsistent with this chapter.

§344.35. Duties and Responsibilities of Irrigators.

(a) An irrigator shall comply with the rules contained in this chapter when performing any or all of the functions described in this section.

(b) An irrigator who performs work for an entity or for an exempt business owner who performs or offers to perform irrigation services shall be knowledgeable of and responsible for all permits, contracts, agreements, advertising, and other irrigation services secured and performed using the irrigator's license.

(c) A licensed irrigator who is employed by an exempt business owner as defined by §344.31 of this title (relating to Exemption for Business Owner Who Provides Irrigation Services) shall supervise all irrigation services of the business, in accordance with this chapter.

(d) A licensed irrigator is responsible for:

(1) using the stamp or rubber seal in accordance with this chapter;

(2) obtaining all permits and inspections required to install an irrigation system;

(3) complying with local regulations;

(4) determining the appropriate backflow prevention method for each irrigation system installation and installing the backflow prevention device correctly;

(5) maintaining landscape irrigation systems records;

(6) conserving water;

(7) developing and following irrigation plan for each new irrigation system;

(8) designing an irrigation system that complies with the requirements of this chapter;

(9) providing on-site supervision of the installation of an irrigation system beginning January 1, 2010;

(10) providing supervision to an irrigation technician while connecting an irrigation system to a water supply; installing, maintaining, altering, repairing, or servicing an irrigation system;

(11) providing supervision to an installer connecting an irrigation system through December 31, 2009;

(12) completing the irrigation system including the final "walk through," completing the maintenance checklist, placing a permanent sticker on the controller or on the maintenance checklist if the irrigation system does not have an automatic controller, and providing a copy of the design plan;

(13) selling, consulting, performing maintenance, alteration, repair, and service of irrigation systems that complies with the requirements of this chapter;

(14) providing advertisements, contracts, and warranties that comply with the requirements of this chapter; and

(15) installing an irrigation system that complies with the requirements of this chapter.

§344.36. Duties and Responsibilities of Installers and Irrigation Technicians.

(a) A licensed installer may connect an irrigation system to a water supply through December 31, 2009. This includes installing an approved backflow prevention method pursuant to §344.50 of this title (relating to Backflow Prevention Methods) when connecting an irrigation system to a potable water supply. Beginning January 1, 2009, a licensed irrigation technician may connect an irrigation system to a water supply, including installing an approved backflow prevention method pursuant to §344.50 of this title and may maintain, alter, repair, service, or direct the installation of irrigation systems under the supervision of an irrigator.

(b) If an installer or irrigation technician connects an irrigation system to a potable water supply, the connection and installation of the backflow prevention method must be as indicated on the site irrigation plan or as directed by the licensed irrigator and documented on the site irrigation plan.

(c) Through December 31, 2009, an installer is responsible for the connection of an irrigation system to a water supply under the supervision of a licensed irrigator.

(d) Beginning January 1, 2009, an irrigation technician, under the supervision of a licensed irrigator, is responsible for:

(1) connecting an irrigation system to a water supply; and

(2) providing on-site supervision of the installation, maintenance, alteration, repair, service of an irrigation system including the final walk through with the irrigation system owner or owner's representative to explain the maintenance and operation of the irrigation system.

§344.38. Irrigator, Installer, and Irrigation Technician Records.

Upon the licensed irrigator obtaining the seal or rubber stamp, in accordance with this chapter, an impression of the seal or rubber stamp will be made on letterhead, or other business stationary, and maintained on file for review by the commission. Archival copies of all records given to the irrigation system's owner or owner's representative shall be maintained by the irrigator. Records will be maintained by the irrigator for a period of three years from the date installation, maintenance, alteration, repair or service was completed. Irrigators, installers, and irrigation technicians shall make all records of landscape irrigation services available within ten business days of any request made by autho-

rized representatives of the commission or the local regulatory authority with jurisdiction over landscape irrigation issues.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803462
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER D. LICENSED IRRIGATOR SEAL

30 TAC §§344.40 - 344.43

STATUTORY AUTHORITY

These new sections are adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; and TWC, §5.105, concerning General Policy. These new sections are also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. These new sections are also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; and TOC, §1903.251, concerning License Required. Finally, these new sections are also adopted under THSC, §341.033, concerning Protection of Public Water Supplies; and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

These adopted new sections implement TWC, §§5.013, 5.102, 5.103, 5.105, and 37.001 - 37.015; TOC, §§1903.001, 1903.002, 1903.053, and 1903.251; and THSC, §341.033 and §341.034.

§344.43. Seal Use.

(a) Irrigators shall:

(1) sign their legal name;

(2) affix the seal above the irrigator's signature; and

(3) include the date of signing (month, day, and year) of each document to which the seal is affixed.

(b) The presence of the irrigator's seal displayed above the irrigator's signature and date on any document constitutes the acceptance of all professional responsibility for the document and the irrigation services performed in accordance with that document.

(c) The irrigator will maintain, for three years, a copy of each document bearing the irrigator's seal.

(d) Once a document containing a seal is issued, the seal may not be altered.

(e) Irrigators shall not use or authorize the use of a seal on any plan or specification created by another irrigator unless the irrigator:

(1) Reviews and makes changes to adapt the plan or specification to the specific site conditions and to address state and local requirements; and

(2) Accepts full responsibility for any alterations to the plan or specification and any downstream consequences.

(f) If an irrigator prepares a portion of a plan or specification, that portion of the design or specification prepared by the irrigator, or under the irrigator's supervision and seal, should be clearly identified.

(g) Irrigators shall sign, seal and date the irrigation plan and specifications, contract, addenda or change orders, warranty, and the maintenance checklist.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803463
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER E. BACKFLOW PREVENTION AND CROSS-CONNECTIONS

30 TAC §§344.50 - 344.52

STATUTORY AUTHORITY

These new sections are adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; and TWC, §5.105, concerning General Policy. These new sections are also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. These new sections are also adopted under TWC, §49.238, concerning Irrigation Systems. These new sections are also adopted under Local Government Code, §401.006, concerning Irrigation Systems. These new sections are also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; and TOC, §1903.251, concerning License Required. Finally, these new sections are also adopted under THSC, §341.033, concerning Protection of Public Water Supplies; and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

These adopted new sections implement TWC, §§5.013, 5.102, 5.103, 5.105, 37.001 - 37.015, and 49.238; Local Government Code, §401.006; TOC, §§1903.001, 1903.002, 1903.053, and 1903.251; and THSC, §341.033 and §341.034.

§344.50. Backflow Prevention Methods.

(a) Any irrigation system that is connected to a public or private potable water supply must be connected through a commission-approved backflow prevention method. The backflow prevention device must be approved by the American Society of Sanitary Engineers; or the Foundation for Cross-Connection Control and Hydraulic Research, University of Southern California; or the Uniform Plumbing Code; or any other laboratory that has equivalent capabilities for both the laboratory and field evaluation of backflow prevention assemblies. The backflow prevention device must be installed in accordance with the laboratory approval standards or if the approval does not include specific installation information, the manufacturer's current published recommendations.

(b) If conditions that present a health hazard exist, one of the following methods must be used to prevent backflow;

(1) An air gap may be used if:

(A) there is an unobstructed physical separation; and

(B) the distance from the lowest point of the water supply outlet to the flood rim of the fixture or assembly into which the outlet discharges is at least one inch or twice the diameter of the water supply outlet, whichever is greater.

(2) Reduced pressure principle backflow prevention assemblies may be used if:

(A) the device is installed at a minimum of 12 inches above ground in a location that will ensure that the assembly will not be submerged; and

(B) drainage is provided for any water that may be discharged through the assembly relief valve.

(3) Pressure vacuum breakers may be used if:

(A) no back-pressure condition will occur; and

(B) the device is installed at a minimum of 12 inches above any downstream piping and the highest downstream opening. Pop-up sprinklers are measured from the retracted position from the top of the sprinkler.

(4) Atmospheric vacuum breakers may be used if:

(A) no back-pressure will be present;

(B) there are no shutoff valves downstream from the atmospheric vacuum breaker;

(C) the device is installed at a minimum of six inches above any downstream piping and the highest downstream opening. Pop-up sprinklers are measured from the retracted position from the top of the sprinkler;

(D) there is no continuous pressure on the supply side of the atmospheric vacuum breaker for more than 12 hours in any 24-hour period; and

(E) a separate atmospheric vacuum breaker is installed on the discharge side of each irrigation control valve, between the valve and all the emission devices that the valve controls.

(c) Backflow prevention devices used in applications designated as health hazards must be tested upon installation and annually thereafter.

(d) If there are no conditions that present a health hazard double check valve backflow prevention assemblies may be used to prevent backflow if the device is tested upon installation and:

(1) a local regulatory authority does not prohibit the use of a double check valve;

(2) backpressure caused by an elevation of pressure in the discharge piping by pump or elevation of piping above the supply pressure which could cause a reversal of the normal flow of water or backsiphonage conditions caused by a reduced or negative pressure in the irrigation system exist; and

(3) test cocks are used for testing only.

(e) If a double check valve is installed below ground:

(1) test cocks must be plugged, except when the double check valve is being tested;

(2) test cock plugs must be threaded, water-tight, and made of non-ferrous material;

(3) a y-type strainer is installed on the inlet side of the double check valve;

(4) there must be a clearance between any fill material and the bottom of the double check valve to allow space for testing and repair; and

(5) there must be space on the side of the double check valve to test and repair the double check valve.

§344.51. Specific Conditions and Cross-Connection Control.

(a) Before any chemical is added to an irrigation system connected to any potable water supply, the irrigation system must be connected through a reduced pressure principle backflow prevention assembly or air gap.

(b) Connection of more than one water source to an irrigation system presents the potential for contamination of the potable water supply if backflow occurs. Therefore, connection of any additional water source to an irrigation system that is connected to the potable water supply can only be done if the irrigation system is connected to the potable water supply through a reduced-pressure principle backflow prevention assembly or an air gap.

(c) Irrigation system components with chemical additives induced by aspiration, injection, or emission system connected to any potable water supply must be connected through a reduced pressure principle backflow device.

(d) If an irrigation system is designed or installed on a property that is served by an on-site sewage facility, as defined in Chapter 285 of this title (relating to On-Site Sewage Facilities), then:

(1) all irrigation piping and valves must meet the separation distances from the On-Site Sewage Facilities system as required for a private water line in §285.91(10) of this title (relating to Minimum Required Separation Distances for On-Site Sewage Facilities);

(2) any connections using a private or public potable water source must be connected to the water source through a reduced pressure principle backflow prevention assembly as defined in §344.50 of this title (relating to Backflow Prevention Methods); and

(3) any water from the irrigation system that is applied to the surface of the area utilized by the On-Site Sewage Facility system must be controlled on a separate irrigation zone or zones so as to allow complete control of any irrigation to that area so that there will not be excess water that would prevent the On-Site Sewage Facilities system from operating effectively.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803464
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER F. STANDARDS FOR DESIGNING, INSTALLING, AND MAINTAINING LANDSCAPE IRRIGATION SYSTEMS

30 TAC §§344.60 - 344.65

STATUTORY AUTHORITY

These new sections are adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; and TWC, §5.105, concerning General Policy. These new sections are also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. These new sections are also adopted under TWC, §49.238, concerning Irrigation Systems. These new sections are also adopted under Local Government Code, §401.006, concerning Irrigation Systems. These new sections are also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; and TOC, §1903.251, concerning License Required. Finally, these new sections are also adopted under THSC, §341.033, concerning Protection of Public Water Supplies; and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

These adopted new sections implement TWC, §§5.013, 5.102, 5.103, 5.105, 37.001 - 37.015, and 49.238; Local Government Code, §401.006; TOC, §§1903.001, 1903.002, 1903.053, and 1903.251; and THSC, §341.033 and §341.034.

§344.60. Water Conservation.

All irrigation systems shall be designed, installed, maintained, altered, repaired, serviced, and operated in a manner that will promote water conservation as defined in §344.1(44) of this title (relating to Definitions).

§344.61. Minimum Standards for the Design of the Irrigation Plan.

(a) An irrigator shall prepare an irrigation plan for each site where a new irrigation system will be installed. A paper or electronic copy of the irrigation plan must be on the job site at all times during the installation of the irrigation system. A drawing showing the actual installation of the system is due to each irrigation system owner after all new irrigation system installations. During the installation of the irrigation system, variances from the original plan may be authorized by the licensed irrigator if the variance from the plan does not:

(1) diminish the operational integrity of the irrigation system;

(2) violate any requirements of this chapter; and

(3) go unnoted in red on the irrigation plan.

(b) The irrigation plan must include complete coverage of the area to be irrigated. If a system does not provide complete coverage of the area to be irrigated, it must be noted on the irrigation plan.

(c) All irrigation plans used for construction must be drawn to scale. The plan must include, at a minimum, the following information:

(1) the irrigator's seal, signature, and date of signing;

(2) all major physical features and the boundaries of the areas to be watered;

(3) a North arrow;

(4) a legend;

(5) the zone flow measurement for each zone;

(6) location and type of each:

(A) controller;

(B) sensor (for example, but not limited to, rain, moisture, wind, flow, or freeze);

(7) location, type, and size of each:

(A) water source, such as, but not limited to a water meter and point(s) of connection;

(B) backflow prevention device;

(C) water emission device, including, but not limited to, spray heads, rotary sprinkler heads, quick-couplers, bubblers, drip, or micro-sprays;

(D) valve, including, but not limited to, zone valves, master valves, and isolation valves;

(E) pressure regulation component; and

(F) main line and lateral piping.

(8) the scale used; and

(9) the design pressure.

§344.62. Minimum Design and Installation Requirements.

(a) No irrigation design or installation shall require the use of any component, including the water meter, in a way which exceeds the manufacturer's published performance limitations for the component.

(b) Spacing.

(1) The maximum spacing between emission devices must not exceed the manufacturer's published radius or spacing of the device(s). The radius or spacing is determined by referring to the manufacturer's published specifications for a specific emission device at a specific operating pressure.

(2) New irrigation systems shall not utilize above-ground spray emission devices in landscapes that are less than 48 inches not including the impervious surfaces in either length or width and which contain impervious pedestrian or vehicular traffic surfaces along two or more perimeters. If pop-up sprays or rotary sprinkler heads are used in

a new irrigation system, the sprinkler heads must direct flow away from any adjacent surface and shall not be installed closer than four inches from a hardscape, such as, but not limited to, a building foundation, fence, concrete, asphalt, pavers, or stones set with mortar.

(3) Narrow paved walkways, jogging paths, golf cart paths or other small areas located in cemeteries, parks, golf courses or other public areas may be exempted from this requirement if the runoff drains into a landscaped area.

(c) Water pressure. Emission devices must be installed to operate at the minimum and not above the maximum sprinkler head pressure as published by the manufacturer for the nozzle and head spacing that is used. Methods to achieve the water pressure requirements include, but are not limited to, flow control valves, a pressure regulator, or pressure compensating spray heads.

(d) Piping. Piping in irrigation systems must be designed and installed so that the flow of water in the pipe will not exceed a velocity of five feet per second for polyvinyl chloride (PVC) pipe.

(e) Irrigation Zones. Irrigation systems shall have separate zones based on plant material type, microclimate factors, topographic features, soil conditions, and hydrological requirements.

(f) Matched precipitation rate. Zones must be designed and installed so that all of the emission devices in that zone irrigate at the same precipitation rate.

(g) Irrigation systems shall not spray water over surfaces made of concrete, asphalt, brick, wood, stones set with mortar, or any other impervious material, such as, but not limited to, walls, fences, sidewalks, streets, etc.

(h) Master valve. When provided, a master valve shall be installed on the discharge side of the backflow prevention device on all new installations.

(i) PVC pipe primer solvent. All new irrigation systems that are installed using PVC pipe and fittings shall be primed with a colored primer prior to applying the PVC cement in accordance with the Uniform Plumbing Code (Section 316) or the International Plumbing Code (Section 605).

(j) Rain or moisture shut-off devices or other technology. All new automatically controlled irrigation systems must include sensors or other technology designed to inhibit or interrupt operation of the irrigation system during periods of moisture or rainfall. Rain or moisture shut-off technology must be installed according to the manufacturer's published recommendations. Repairs to existing automatic irrigation systems that require replacement of an existing controller must include a sensor or other technology designed to inhibit or interrupt operation of the irrigation system during periods of moisture or rainfall. El Paso, Hudspeth, Culberson, Jeff Davis, Presidio, Brewster, Terrell, Loving, Winkler, Ward, Reeves, Ector, Crane and Pecos are excluded from this requirement.

(k) Isolation valve. All new irrigation systems must include an isolation valve between the water meter and the backflow prevention device.

(l) Depth coverage of piping. Piping in all irrigation systems must be installed according to the manufacturer's published specifications for depth coverage of piping.

(1) If the manufacturer has not published specifications for depth coverage of piping, the piping must be installed to provide minimum depth coverage of six inches of select backfill, between the top of the pipe and the natural grade of the topsoil. All portions of the irrigation system that fail to meet this standard must be noted on the irrigation plan. If the area being irrigated has rock at a depth of six inches or less, select backfill may be mounded over the pipe. Mounding must be noted on the irrigation plan and discussed with the irrigation system owner or owner's representative to address any safety issues.

(2) If a utility, man-made structure, or roots create an unavoidable obstacle, which makes the six-inch depth coverage requirement impractical, the piping shall be installed to provide a minimum of two inches of select backfill between the top of the pipe and the natural grade of the topsoil.

(3) All trenches and holes created during installation of an irrigation system must be backfilled and compacted to the original grade.

(m) Wiring irrigation systems.

(1) Underground electrical wiring used to connect an automatic controller to any electrical component of the irrigation system must be listed by Underwriters Laboratories as acceptable for burial underground.

(2) Electrical wiring that connects any electrical components of an irrigation system must be sized according to the manufacturer's recommendation.

(3) Electrical wire splices which may be exposed to moisture must be waterproof as certified by the wire splice manufacturer.

(4) Underground electrical wiring that connects an automatic controller to any electrical component of the irrigation system must be buried with a minimum of six inches of select backfill.

(n) Water contained within the piping of an irrigation system is deemed to be non-potable. No drinking or domestic water usage, such as, but not limited to, filling swimming pools or decorative fountains, shall be connected to an irrigation system. If a hose bib (an outdoor water faucet that has hose threads on the spout) is connected to an irrigation system for the purpose of providing supplemental water to an area, the hose bib must be installed using a quick coupler key on a quick coupler installed in a covered purple valve box and the hose bib and any hoses connected to the bib must be labeled "non-potable, not safe for drinking." An isolation valve must be installed upstream of a quick coupler connecting a hose bib to an irrigation system.

(o) Beginning January 1, 2010, either a licensed irrigator or a licensed irrigation technician shall be on-site at all times while the landscape irrigation system is being installed. When an irrigator is not on-site, the irrigator shall be responsible for ensuring that a licensed irrigation technician is on-site to supervise the installation of the irrigation system.

§344.63. Completion of Irrigation System Installation.

Upon completion of the irrigation system, the irrigator or irrigation technician who provided supervision for the on-site installation shall be required to complete four items:

(1) a final "walk through" with the irrigation system's owner or the owner's representative to explain the operation of the system;

(2) The maintenance checklist on which the irrigator or irrigation technician shall obtain the signature of the irrigation system's owner or owner's representative and shall sign, date, and seal the checklist. If the irrigation system's owner or owner's representative is unwilling or unable to sign the maintenance checklist, the irrigator shall note the time and date of the refusal on the irrigation system's owner or owner's representative's signature line. The irrigation system owner or owner's representative will be given the original maintenance checklist and a duplicate copy of the maintenance checklist shall be

maintained by the irrigator. The items on the maintenance checklist shall include but are not limited to:

(A) the manufacturer's manual for the automatic controller, if the system is automatic;

(B) a seasonal (spring, summer, fall, winter) watering schedule based on either current/real time evapotranspiration or monthly historical reference evapotranspiration (historical ET) data, monthly effective rainfall estimates, plant landscape coefficient factors, and site factors;

(C) a list of components, such as the nozzle, or pump filters, and other such components; that require maintenance and the recommended frequency for the service; and

(D) the statement, "This irrigation system has been installed in accordance with all applicable state and local laws, ordinances, rules, regulations or orders. I have tested the system and determined that it has been installed according to the Irrigation Plan and is properly adjusted for the most efficient application of water at this time."

(3) A permanent sticker which contains the irrigator's name, license number, company name, telephone number and the dates of the warranty period shall be affixed to each automatic controller installed by the irrigator or irrigation technician. If the irrigation system is manual, the sticker shall be affixed to the original maintenance checklist. The information contained on the sticker must be printed with waterproof ink and include:

(4) The irrigation plan indicating the actual installation of the system must be provided to the irrigation system's owner or owner representative.

§344.64. Maintenance, Alteration, Repair, or Service of Irrigation Systems.

(a) The irrigator is responsible for all work that the irrigator performed during the maintenance, alteration, repair, or service of an irrigation system during the warranty period. The irrigator or business owner is not responsible for the professional negligence of any other irrigator who subsequently conducts any irrigation service on the same irrigation system.

(b) All trenches and holes created during the maintenance, alteration, repair, or service of an irrigation system must be returned to the original grade with compacted select backfill.

(c) Colored PVC pipe primer solvent must be used on all pipes and fittings used in the maintenance, alteration, repair, or service of an irrigation system in accordance with the Uniform Plumbing Code (Section 316) or the International Plumbing Code (Section 605).

(d) When maintenance, alteration, repair or service of an irrigation system involves excavation work at the water meter or backflow prevention device, an isolation valve shall be installed, if an isolation valve is not present.

§344.65. Reclaimed Water.

Reclaimed water may be utilized in landscape irrigation systems if:

(1) there is no direct contact with edible crops, unless the crop is pasteurized before consumption;

(2) the irrigation system does not spray water across property lines that do not belong to the irrigation system's owner;

(3) the irrigation system is installed using purple components;

(4) the domestic potable water line is connected using an air gap or a reduced pressure principle backflow prevention device, in accordance with §290.47(i) of this title (relating to Appendices);

(5) a minimum of an eight inch by eight inch sign, in English and Spanish, is prominently posted on/in the area that is being irrigated, that reads, "RECLAIMED WATER - DO NOT DRINK" and "AGUA DE RECUPERACIÓN - NO BEBER"; and

(6) backflow prevention on the reclaimed water supply line shall be in accordance with the regulations of the water purveyor.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803465
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER G. ADVERTISING, CONTRACT, AND WARRANTY

30 TAC §§344.70 - 344.72

STATUTORY AUTHORITY

These new sections are adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; and TWC, §5.105, concerning General Policy. These new sections are also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. These new sections are also adopted under TWC, §49.238, concerning Irrigation Systems. This new section is also adopted under Local Government Code, §401.006, concerning Irrigation Systems. These new sections are also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; and TOC, §1903.251, concerning License Required. Finally, these new sections are also adopted under THSC, §341.033, concerning Protection of Public Water Supplies; and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

These adopted new sections implement TWC, §§5.013, 5.102, 5.103, 5.105, 37.001 - 37.015, and 49.238; Local Government Code, §401.006; TOC, §§1903.001, 1903.002, 1903.053, and 1903.251; and THSC, §341.033 and §341.034.

§344.70. Advertisement.

(a) All vehicles used in the performance of irrigation installation, maintenance, alteration, repair, or service must display the irriga-

tor's license number in the form of "LI_____" in a contrasting color of block letters at least two inches high, on both sides of the vehicle.

(b) All forms of written and electronic advertisements for irrigation services must display the irrigator's license number in the form of "LI_____." Any form of advertisement, including business cards, and estimates which displays an entity's or individual's name other than that of the licensed irrigator must also display the name of the licensed irrigator and the licensed irrigator's license number. Trailers that advertise irrigation services must display the irrigator's license number.

(c) The name, mailing address, and telephone number of the commission must be prominently displayed on a legible sign and displayed in plain view for the purpose of addressing complaints at the permanent structure where irrigation business is primarily conducted and irrigation records are kept.

§344.71. Contracts.

(a) All contracts to install an irrigation system must be in writing and signed by each party and must specify the irrigator's name, license number, business address, current business telephone numbers, the date that each party signed the agreement, the total agreed price, and must contain the statement, "Irrigation in Texas is regulated by the Texas Commission on Environmental Quality (TCEQ), MC-178, P.O. Box 13087, Austin, Texas 78711-3087. TCEQ's website is: www.tceq.state.tx.us." All contracts must include the irrigator's seal, signature, and date.

(b) All written estimates, proposals, bids, and invoices relating to the installation or repair of an irrigation system(s) must include the irrigator's name, license number, business address, current business telephone number(s), and the statement: "Irrigation in Texas is regulated by the Texas Commission On Environmental Quality (TCEQ) (MC-178), P.O. Box 13087, Austin, Texas 78711-3087. TCEQ's web site is: www.tceq.state.tx.us."

(c) An individual who agrees by contract to provide irrigation services as defined in §344.30 of this title (relating to License Required) shall hold an irrigator license issued under Chapter 30 of this title (relating to Occupational Licenses and Registrations) unless the contract is a pass-through contract as defined in §344.1(36) of this title (relating to Definitions). If a pass-through contract includes irrigation services, then the irrigation portion of the contract can only be performed by a licensed irrigator. If an irrigator installs a system pursuant to a pass-through contract, the irrigator shall still be responsible for providing the irrigation system's owner or through contract, the irrigator shall still be responsible for providing the irrigation system's owner or owner's representative a copy of the warranty and all other documents required under this chapter. A pass-through contract must identify by name and license number the irrigator that will perform the work and must provide a mechanism for contacting the irrigator for irrigation system warranty work.

(d) The contract must include the dates that the warranty is valid.

§344.72. Warranties.

(a) On all installations of new irrigation systems, an irrigator shall present the irrigation system's owner or owner's representative with a written warranty covering materials and labor furnished in the new installation of the irrigation system. The irrigator shall be responsible for adhering to terms of the warranty. If the irrigator's warranty is less than the manufacturer's warranty for the system components, then the irrigator shall provide the irrigation system's owner or the owner's representative with applicable information regarding the manufacturer's warranty period. The warranty must include the irrigator's seal, signature, and date. If the warranty is part of an irrigator's contract, a separate warranty document is not required.

(b) An irrigator's written warranty on new irrigation systems must specify the irrigator's name, business address, and business telephone number(s), must contain the signature of the irrigation system's owner or owner's representative confirming receipt of the warranty and must include the statement: "Irrigation in Texas is regulated by the Texas Commission on Environmental Quality (TCEQ), MC-178, P.O. Box 130897, Austin, Texas 78711-3087. TCEQ's website is: www.tceq.state.tx.us."

(c) On all maintenance, alterations, repairs, or service to existing irrigation systems, an irrigator shall present the irrigation system's owner or owner's representative a written document that identifies the materials furnished in the maintenance, alteration, repair, or service. If a warranty is provided, the irrigator shall abide by the terms. The warranty document must include the irrigator's name and business contact information.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803466
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

♦ ♦ ♦

SUBCHAPTER H. IRRIGATOR ADVISORY COUNCIL

30 TAC §344.80

STATUTORY AUTHORITY

This new section is adopted under Texas Water Code (TWC), §5.013, concerning the General Jurisdiction of the Commission; TWC, §5.102, concerning General Powers; TWC, §5.103, concerning Rules; TWC, §5.105, concerning General Policy; and TWC, §5.107, concerning Advisory Committees, Work Groups, and Task Forces. This new section is also adopted under TWC, §§37.001 - 37.015, concerning: Definitions; Rules; License or Registration Required; Qualifications; Issuance and Denial of Licenses and Registrations; Renewal of License or Registration; Licensing Examinations; Training; Continuing Education; Fees; Advertising; Complaints; Compliance Information; Practice of Occupation; Roster of License Holders and Registrants; and Power to Contract, respectively. This new section is also adopted under TWC, §49.238, concerning Irrigation Systems. This new section is also adopted under Local Government Code, §401.006, concerning Irrigation Systems. This new section is also adopted under TOC, §1903.001, concerning Definitions; TOC, §1903.002, concerning Exemptions; TOC, §1903.053, concerning Standards; TOC, §1903.151 concerning Council Membership; TOC, §1903.152, concerning Eligibility of Public Members; TOC, §1903.155, concerning Presiding Officer; TOC, §1903.157, concerning Meetings; TOC, §1903.158 concerning Per Diem Reimbursement; TOC, §1903.159, concerning Council Duties; and TOC, §1903.251, concerning License Required.

Finally, this new section is also adopted under THSC, §341.033, concerning Protection of Public Water Supplies; and THSC, §341.034, concerning Licensing and Registration of Persons Who Perform Duties Relating to Public Water Supplies.

This adopted new section implements TWC, §§5.013, 5.102, 5.103, 5.105, 5.107, 37.001 - 37.015, and 49.238; Local Government Code, §401.006; TOC, §§1903.001, 1903.002, 1903.053, 1903.151, 1903.152, 1903.155, 1903.157, 1903.158, 1903.159, and 1903.251; and THSC, §341.033 and §341.034.

§344.80. Irrigator Advisory Council.

(a) The Irrigator Advisory Council is composed of nine members that are appointed by the commission. Appointments to the council will be made without regard to race, creed, sex, religion, or national origin of the appointees. The purpose of the council is to give the commission the benefit of the members' collective business, environmental, and technical expertise and experience with respect to matters relating to landscape irrigation. The council has no executive or administrative powers or duties with respect to the operation of the commission, and all such powers and duties rest solely with the commission.

(b) Six members of the council must be licensed irrigators who are residents of the State of Texas, experienced in the irrigation business, and familiar with irrigation methods and techniques.

(c) Three members must be representatives of the public. A person is not eligible for appointment as a public member if the person or the person's spouse:

(1) is licensed by an occupational regulatory agency in the field of irrigation; or

(2) is employed by, participates in the management of, or has, other than as a consumer, a financial interest in a business entity or other organization related to the field of irrigation.

(d) It is grounds for removal from the council by the commission if a member:

(1) does not meet, at the time of the appointment, the qualifications that are required by subsection (b) or (c) of this section for appointment to the council;

(2) does not maintain, during service on the council, the qualifications that are required by subsection (b) or (c) of this section for appointment to the council; or

(3) misses three consecutive regularly scheduled meetings or more than half of all the regularly scheduled meetings in a one-year period.

(e) The members of the council serve six-year terms, with the terms expiring February 1 of each odd-numbered year.

(f) A member of the council is entitled to per diem as appropriated by the Texas Legislature for each day that the member engages in the business of the council. A member is entitled to reimbursement for travel expenses, including expenses for meals and lodging, as provided for in the General Appropriations Act.

(g) The council shall hold meetings at the call of the commission or chairman.

(h) A majority of the council constitutes a quorum for conducting business.

(i) The council will elect a chairman by a majority vote.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2008.

TRD-200803467
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: January 1, 2009
Proposal publication date: February 1, 2008
For further information, please call: (512) 239-0177

REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

Adopted Rule Review

Texas Department of Agriculture

Title 4, Part 1

The Texas Department of Agriculture (the department) adopts the review of Title 4, Texas Administrative Code, Part 1, Chapter 17, Subchapters A - H, concerning Marketing and Promotion, and readopts all sections in Chapter 17, Subchapters A - H. The notice of intent to review was published in the May 23, 2008, issue of the *Texas Register* (33 TexReg 4199). No comments were received on the proposal.

The Government Code, §2001.039, requires state agencies to review and consider for readoption each of their rules every four years. The review must include an assessment of whether the original justification for the rules continues to exist. The assessment of Title 4, Texas Administrative Code, Part 1, Chapter 17, Subchapters A - H, by the department at this time indicates that the reason for readopting without changes all sections in Chapter 17, Subchapters A - H continues to exist.

TRD-200803496
Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
Filed: July 8, 2008

♦ ♦ ♦

TABLES & GRAPHICS

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure: 28 TAC §3.3829(b)(8)(H)

Long-Term Care Insurance
Personal Worksheet

FOR THE STATE OF TEXAS

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [$ _____ per month, or $ ____ per year] [a one-time single premium of $ _____ .]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums:_____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.]

Instructions to Company: Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.

Rate Increase History

We have sold long-term care insurance since [year] and have sold this [policy/rider], Form No.[____] since (year). [We have never raised rates for any long-term care (policy/rider) sold in this state or any other state.] [We have not raised rates for this (policy/rider) or a similar (policy/rider) in this state or any other state in the last ten years.] [We have raised rates on this (policy/rider) or a similar (policy/rider) in the last ten years. Following is a summary of the rate increases:]

Instructions to Company: A company may use the first bracketed sentence above only if it has never increased rates under any prior individual or group policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar individual or group policy forms in this state or any other state during the last 10 years. The list shall specify the individual or group policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

[☐Have you considered whether you could afford to keep this policy if the premiums went up, for example by 20%?]

Instructions to Company: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one) ☐ Under $10,000 ☐ $[10-20,000] ☐ $[20-30,000] ☐ $[30-50,000] ☐ Over $50,000

Instructions to Company: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐F rom my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Instructions to Company: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days_____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Questions Related to Your Needs

Are you aware you need to be unable to perform two (2) of the following six (6) activities of daily living (ADLs) - bathing, continence, dressing, eating, toileting, and moving around - prior to your long-term care benefits being triggered? ☐ YES ☐ NO

Are you aware of the term "cognitive impairment"? ☐ YES ☐ NO

Companies selling long-term care policies must offer a policy that pays benefits based on your cognitive impairment or your inability to perform two (2) ADLs. Do you understand this policy limitation? ☐ YES ☐ NO

What type of long-term care service do you anticipate utilizing? (check all that apply)

□ Nursing home care □ Assisted living care □ Home health care □ Adult day care
□ Hospice care □ Respite care □ other services

Disclosure Statement

☐ ☐	The answers to the questions above describe my financial situation. OR I choose not to complete this information. (Check one.)
☐	I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** ***Instructions to Company:*** This box must be checked.

Signed: _____ _____
(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed: _____ _____
(Agent) (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____]
(Applicant) (Date)

Instructions to Company: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Instructions to Company: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

Form Number LHL560(LTC)

Figure: 28 TAC §3.3829(b)(8)(I)

Instructions to Company: This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

FOR THE STATE OF TEXAS

Long-Term Care Insurance Potential Rate Increase Disclosure Form

(Company Name, address & phone number)

1. (Premium rate/Premium rate schedules) that (is/are) applicable to you and that will be in effect until a request is made and filed with the Texas Department of Insurance for an increase (is/are) ($_____) shown on the application. The (premium/premium rate schedule) for this coverage will be (shown on the schedule page of/attached to) your (policy/rider).

2. If your rates are changed, the new rates will become effective on the (next anniversary date/next billing date, etc.). The new rates will remain in effect until another request is made and filed with the Texas Department of Insurance. You have the right to receive a revised (premium rate/premium rate schedule) if the (premium/premium rate schedule) is changed.

3. This long-term care coverage is Guaranteed Renewable. This means that the rates for this coverage may be increased in the future. Your rates CANNOT be increased due to (your increasing age or) declining health, but your rates may go up based on the experience of all insureds with a (policy/rider) similar to yours.

4. If you receive a (premium rate/premium rate schedule) increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

(a) Pay the increased premium and continue your coverage in force as is.

(b) Reduce your coverage benefits to a level such that your premiums will not increase.

(c) Exercise your long-term care nonforfeiture option, if purchased. This option is available for purchase for an additional premium.

(d) Exercise your contingent nonforfeiture rights - See No. 5. This option is available if you do not purchase a long-term care nonforfeiture option mentioned in (c) above.

5. Contingent Nonforfeiture Rights

If the premium rate for your (policy/rider) goes up in the future and you do not buy a long-term care nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

(a) You will keep some long-term care insurance coverage, if:

(1) Your premium after the increase exceeds your original premium by the percentage shown, or more, in the table (provided on the next page/below); and

(2) You do not pay your premium within 120 days of the increase causing your (policy/rider) to lapse.

(b) The amount of coverage, new lifetime maximum benefit amount, etc., you will keep will equal the total amount of premiums you have paid since your (policy/rider) was first issued. If you have already received benefits under the (policy/rider), so that the remaining maximum benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount.

(c) Except for this reduced lifetime maximum benefit amount, all other (policy/rider) benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your (policy/rider), with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the (policy/rider) at age 65 and paid the $1,000 annual premium for ten years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to not pay any more premiums causing your (policy/rider) to lapse.
- Your "paid-up" (policy/rider) benefits are $10,000, provided you have at least $10,000 of benefits remaining under your (policy/rider).

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Nonforfeiture Table

Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%

64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

6. Fixed or Limited Premium Payment Period

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies or certificates that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent nonforfeiture benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

(a) The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65 - 80	30%
Over 80	10%

(b) You stop paying your premiums within 120 days of when the premium increase took effect; AND

(c) The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

(1) The total lifetime amount of benefits your reduced paid up policy or certificate will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy or certificate becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

(2) The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy or certificate at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy or certificate benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy or certificate.

Form Number LHL561(LTC)

Figure: 28 TAC §3.3837(a)(2)

Long-Term Care Insurance
Replacement and Lapse Reporting Form

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

For the State of _____ For the Reporting Year of _____

Company Name: _____

Company Address: _____

_____

Company NAIC Number: _____

Contact Person: _____ Phone Number: (____)_____

Instructions

The purpose of this form is to specify the information regarding long-term care insurance policy replacements and lapses that insurers are required to report to the Commissioner of Insurance on a statewide basis. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. The following two tables indicate the information required in reporting the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold by this Agent	Number of Policies Replaced by this Agent	Number of Replacements as % of Number Sold by this Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold by this Agent	Number of Policies Lapsed by this Agent	Number of Lapses as % of Number Sold by this Agent

The following table indicates the number of replacement long-term care policies sold as a percentage of the insurer's total annual sales of such policies and the number of lapsed long-term care policies as a percentage of the insurer's total annual sales of such policies.

Company Totals

Company Name: _____

Report Year _____

Replacement Policies Sold	
Annual Policies Sold	
Policies in Force (as of the end of the preceding calendar year)	
% of Replacement Policies Sold to Annual Policies Sold (as of the end of the preceding calendar year)	
% of Replacement Policies Sold to Policies in Force (as of the end of the preceding calendar year)	
Policies Lapsed	
% of Policies Lapsed to Annual Policies Sold (as of the end of the preceding calendar year)	
% of Policies Lapsed to Policies in Force (as of the end of the preceding calendar year)	

Form Number LHL562(LTC)

Figure: 28 TAC §3.3837(b)

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES

FOR THE STATE OF TEXAS

FOR THE REPORTING YEAR ____

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____

Address: _____

_____

Phone Number _____

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates for the preceding calendar year. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

_____

_____

_____

_____

_____

Signature

_____

Name and Title (please print)

_____

Date

Form Number LHL563(LTC)

Figure: 28 TAC §3.3837(c)(2)

Long-Term Care Insurance
Claim Denials Reporting Form

FOR THE STATE OF TEXAS

For the Reporting Year of _____

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____
Company Address: _____
_____
Company NAIC Number: _____
Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. "Claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

Indicate the manner of reporting by checking one of the boxes below.

☐ Per Claimant - counts each individual who makes one or a series of claim requests

☐ Per Transaction - counts each claim request

"Denied" means a claim that is not paid for any reason other than for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

		State Data	**Nationwide Data[1]**
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 divided by Line 1)		

7	Number of Long-Term Care Claims Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit eligibility Criteria Not Met[4]		
11	• Other[5]		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example: home health care claim filed under a nursing home only policy.
3. Example: a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples: (i) a benefit trigger not met; (ii) certification by a licensed health care practitioner not provided; (iii) no plan of care.
5. Examples: duplicate submission, incomplete claim submission, advance billing.

Form Number LHL564(LTC)

Figure: 28 TAC §3.3837(e)

LONG-TERM CARE POLICIES SOLD REPORTING FORM
FOR THE REPORTING YEAR ____

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____

NAIC ID Number: _____

TDI ID Number: _____

Instructions: Please include certificates and riders in the information reported below.

Long-Term Care Partnership Policy Type	**Number Sold**	**Average Age**
Comprehensive (institutional and community care)		
Nursing Home (institutional only)		

Long-Term Care Non-Partnership Policy Type	**Number Sold**	**Average Age**
Comprehensive (institutional and community care)		
Nursing Home (institutional only)		
Home Health Care (community-based services)		
Riders (attached to life policies, annuity contracts)		

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL565(LTC)

Figure: 28 TAC §3.3837(f)

LONG-TERM CARE SUITABILITY REPORTING FORM
FOR THE REPORTING YEAR ____

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____

NAIC ID Number: _____

TDI ID Number: _____

Suitability Data for Partnership Policies

Long-term Care Partnership Policies	Total Number of Applications Received	Total Number of Applicants Who Declined to Provide Personal Worksheet Information	Total Number of Applicants Who Did Not Meet Suitability Standards	Total Number of Applicants Who Chose to Confirm After Receiving a Suitability Letter
Comprehensive (institutional and community care)				
Nursing Home (institutional only)				

Suitability Data for Non-Partnership Policies

Long-term Care Non- Partnership Policies	Total Number of Applications Received	Total Number of Applicants Who Declined to Provide Personal Worksheet Information	Total of Applicants Who Did Not Meet Suitability Standards	Total Number of Applicants Who Chose to Confirm After Receiving a Suitability Letter
Comprehensive (institutional and community care)				
Nursing Home (institutional only)				

Home Health Care (community-based services)				
Riders (attached to life policies, annuity contracts)				

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL566(LTC)

Figure: 28 TAC §3.3842(i)(7)

Things You Should Know Before You Buy
Long-Term Care Insurance

Long-Term Care Insurance	• A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it. • [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Instructions to Company: For single premium policies, delete both of the sentences in the second bullet, and for noncancellable policies, delete the second sentence only in the second bullet.

	• The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does **not** pay for most long-term care.
Medicaid	• Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid. • Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services. • When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets. • Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency at 1-800-252-8263 or call 211.
Shopper's Guide	• Make sure the insurance company or agent gives you a copy of a booklet entitled "Long-Term Care Insurance" published by the Texas Department of Insurance. Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	• The Texas Health Information Counseling and Advocacy Program (HICAP) offers free one-to-one counseling services, concerning whether a long-term care insurance is a suitable option for you, that can be accessed through the toll free number 1-800-252-9250. For insurance agent, insurance company and any other long-term care insurance information, you may call the Consumer Help Line of the Texas Department of Insurance at 1-800-252-3439.

Facilities	• Some long-term care insurance contracts provide for benefit payments in certain facilities only if the facilities are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Form Number LHL567(LTC)

Figure: 28 TAC §3.3842(j)

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Long-Term Care Insurance" published by the Texas Department of Insurance and the disclosure form entitled "Things You Should Know Before Buying Long-Term Care Insurance." The Texas Department of Insurance also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy. You may contact the Department at 1-800-252-3439 or you may go to the Department's web site at www.tdi.state.tx.us.

[You either did not provide any financial information or provided insufficient financial information for us to review.]

Instructions to Company: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application, and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ **Yes,** [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

***Instructions to Company*:** Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE **DATE**

Please return to [issuer] at [address] by [date].

Form Number LHL568(LTC)

Figure: 28 TAC §3.3844(g)(2)

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65 - 80	30%
Over 80	10%

Figure: 28 TAC §3.3848(b)(5)(C)(ii)

Return of Premium Schedule

Long Term Care policy, certificate, or rider with n-premium payment options where n = 5, 6, 7, 8, 9, 10

n = 10		n = 9		n = 8		n = 7		n = 6		n = 5	
Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid
1	0%	1	0%	1	0%	1	0%	1	0%	1	0%
2	5%	2	6%	2	7%	2	8%	2	9%	2	10%
3	10%	3	12%	3	14%	3	16%	3	18%	3	20%
4	15%	4	18%	4	21%	4	24%	4	27%	4	30%
5	20%	5	24%	5	28%	5	32%	5	36%	5	40%
6	25%	6	30%	6	35%	6	40%	6	45%		
7	30%	7	36%	7	42%	7	48%				
8	35%	8	42%	8	49%						
9	40%	9	48%								
10	45%										

Important Notice: After the end of the [nth] policy year, there will be no return of premium.

Source: Texas Department of Insurance

Form Number LHL574(LTC)

Figure: 28 TAC §3.3849(e)(1)(F)

Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates

Due annually between January 1 and January 31 for the preceding calendar year

---

Company Name _____

NAIC ID Number _____

For Calendar Year _____

Date Submitted _____

TDI ID Number _____

I hereby certify that:

Each association as defined in the Insurance Code §1251.052 to whom (company name) has issued a long-term care partnership policy or certificate or non-partnership policy or certificate during (calendar year) has met the requirements of the Texas Administrative Code §3.3849 (relating to Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies).

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL573(LTC)

Figure: 28 TAC §3.3871(a)(2)(B)(vii)

Partnership Status Disclosure Notice for Long Term Care Partnership Policies/Certificates

Important Information Regarding the Texas Long-Term Care Insurance Partnership Program

Note: It is very important that you keep this Disclosure Notice with your Long-Term Care insurance Policy or Certificate.

Insured Name: _____

Policy Name: _____

Date of Issue: _____

The long-term care insurance policy [certificate] that you have purchased currently qualifies for the Texas Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] may protect your assets through a feature known as an "Asset Disregard," under the Texas Medicaid program. In accordance with the Texas Insurance Code §1651.106, if the partnership for long-term care program is discontinued, an individual who purchased an approved plan before the date the partnership program is discontinued remains eligible to receive dollar-for-dollar asset disregard and asset protection under the Texas Medicaid program.

Asset Disregard means that the amount of the policyholder's [certificate holder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy [certificate] that is not a Partnership Policy [Certificate]. ***The purchase of a Partnership policy, however, does not guarantee you the ability to disregard assets. In addition, the purchase of a Partnership Policy does not automatically qualify you for Medicaid.***

Partnership Policy [Certificate] Status. Your long-term care insurance policy [certificate] is intended to qualify as a Partnership Policy [Certificate] under the Texas Long-Term Care Partnership Program as of your Policy's [Certificate's] effective date.

What Could Disqualify Your Policy [Certificate] Status as a Partnership Policy. If you make any changes to your policy [certificate], such changes could affect whether your policy [certificate] continues to be a Partnership Policy. **Before you make any changes, you should consult with [insert name of insurance company] to determine the effect of a proposed change.** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Partnership Policy [Certificate], you may not receive beneficial treatment of your policy [certificate] such as asset disregard under the Medicaid program of that State. The information contained in this Endorsement is based on current Texas and Federal laws. These laws are subject to change.

Additional Information. If you have questions regarding your insurance policy [certificate] please contact [insert the name of insurer]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Texas Health and Human Services Commission by calling 1-800-252-8263 or 211.

Form Number LHL569(LTC)

Figure: 28 TAC §3.3873(a)(2)(F)

Long-Term Care Partnership Program Insurer Certification Form

Section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), authorizes the Texas Commissioner of Insurance upon implementing a qualified State long-term care insurance partnership program ("Qualified Partnership") to certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specific provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) (referred to herein as the "2000 Model Regulation" and "2000 Model Act" respectively).

In order to provide the Commissioner of Insurance with information necessary to provide a certification for policies, this Issuer Certification Form requests information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership Program of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

_____
_____
_____

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

_____
_____
_____

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form:

_____
_____
_____

Copies of each of the above referenced policy forms, including any riders and endorsements, shall be provided if required under the provisions of 28 TAC §3.3873 (pertaining to Filing Requirements for Long-Term Care Partnership Policies).

II. QUESTIONS REGARDING APPLICABLE PROVISIONS OF THE 2000 MODEL REGULATION AND 2000 MODEL ACT

Please answer each of the questions below with respect to the policy forms identified in section I.C above. For purposes of answering the questions below, any provision of the 2000 Model Regulation or 2000 Model Act listed below shall be treated as including any other provision of the 2000 Model Regulation or 2000 Model Act necessary to implement the provision.

Are the following requirements of the 2000 Model Regulation met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership Program that are issued on each of the policy forms identified in Section I.C above?

Yes___ No___ N/A___ A. Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the 2000 Model Act relating to such section 6A.

Yes___ No___ N/A___ B. Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

Yes___ No___ N/A___ C. Section 6C (relating to extension of benefits).

Yes___ No___ N/A___ D. Section 6D (relating to continuation or conversion of coverage).

Yes___ No___ N/A___ E. Section 6E (relating to discontinuance and replacement of policies).

Yes___ No___ N/A___ F. Section 7 (relating to unintentional lapse).

Yes___ No___ N/A___ G. Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

Yes___ No___ N/A___ H. Section 9 (relating to required disclosure of rating practices to consumer).

Yes___ No___ N/A___ I. Section 11 (relating to prohibitions against post-claims underwriting).

Yes___ No___ N/A___ J. Section 12 (relating to minimum standards).

Yes___ No___ N/A___ K. Section 14 (relating to application forms and replacement coverage).

Yes___ No___ N/A___ L. Section 15 (relating to reporting requirements).

Yes___ No___ N/A___ M. Section 22 (relating to filing requirements for marketing).

Yes___ No___ N/A___ N. Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

Yes___ No___ N/A___ O. Section 24 (relating to suitability).

Yes___ No___ N/A___ P. Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

Yes___ No___ N/A___ Q. Section 26 (the provisions relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 U.S.C. 7702BJ(g)(4)).

Yes___ No___ N/A___ R. Section 29 (relating to standard format outline of coverage).

Yes___ No___ N/A___ S. Section 30 (relating to requirement to deliver shopper's guide).

Are the following requirements of the 2000 Model Act met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership Program that are issued on each of the policy forms identified in section I.C above?

Yes___ No___ N/A___ A. Section 6C (relating to preexisting conditions).

Yes___ No___ N/A___ B. Section 6D (relating to prior hospitalization).

Yes___ No___ N/A___ C. Section 8 (provisions relating to contingent nonforfeiture benefits).

Yes___ No___ N/A___ D. Section 6F (relating to right to return).

Yes___ No___ N/A___ E. Section 6G (relating to outline of coverage).

Yes___ No___ N/A___ F. Section 6H (relating to requirements for certificates under group plans).

Yes___ No___ N/A___ G. Section 6J (relating to policy summary).

Yes___ No___ N/A___ H. Section 6K (relating to monthly reports on accelerated death benefits).

Yes___ No___ N/A___ I. Section 7 (relating to incontestability period).

In order for a policy to be covered under the Qualified Partnership Program of the State, the answers to all questions above should be "yes" (or "N/A" where all requirements with respect to a provision above are not applicable). If answers differ between policy forms (*e.g.*, a requirement would be answered "Yes" for one form and "N/A" for another), you should use separate Issuer Certification Forms for such policies.

III. CERTIFICATION

I hereby certify that the policy forms and endorsements identified in Section C above meet all of the requirements of the 2000 National Association of Insurance Commissioners' Long-Term Care Model Act and Model Regulations that are specified in the Federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171) and further certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

_____ _____

Date Name and Title of Officer of the Issuer

_____

Signature of Officer of the Issuer

Form Number LHL570(LTC)

Figure: 28 TAC §3.3874(b)(6)(A)

Long-Term Care Partnership Agent Training Certification
Initial Reporting Form
To be submitted to the Department by January 31, 2009

Company Name _____

NAIC ID Number _____

Date Report Submitted _____

TDI ID Number _____

I hereby certify that:

Each individual who currently sells a long-term care benefit plan for (company name) under the Long-Term Care Partnership Program has completed training and demonstrated evidence of understanding long-term care partnership policies and how they relate to other public and private coverage of long-term care.

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL571(LTC)

Figure: 28 TAC §3.3874(b)(6)(B)

Long-Term Care Partnership Agent Training Certification
To be submitted to the Department annually between January 1 and January 31 for the preceding year beginning in 2010

Company Name _____

Reporting for Year _____

NAIC ID Number _____

Date Report Submitted _____

TDI ID Number _____

I hereby certify that for the annual period specified above:

Each individual who currently sells or who has sold a long-term care benefit plan for (company name) under the Long-term care Partnership Program completed training and demonstrated evidence of understanding long-term care partnership policies and how they relate to other public and private coverage of long-term care.

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL572(LTC)

IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Texas State Affordable Housing Corporation

Notice of Funding Availability

The Texas State Affordable Housing Corporation hereby gives Notice of Funding Availability (NOFA) for the Texas Foundations Fund. Funding availability for the 2008 Texas Foundations Fund is $250,000, up to $50,000 per grant. Eligible grant applicants are nonprofit organizations and rural government entities located in cities with a population less than 50,000 or counties with a population less than 100,000, not located in a federal Metropolitan Statistical Area, as of the last census. The threshold requirements for all proposals are 1) that the Project serves low-income individuals and/or families (50 % or below the Area Median Income adjusted for family size); 2) that the Project meets the Texas Foundations Fund Guidelines, including all program requirements, especially verifying that the Project is for the construction, rehabilitation, and/or critical repair of single family homes for homeowners who are Texas residents of very low-income or extremely low-income; OR the provision of supportive housing for very low-income residents of multifamily apartment complexes; and 3) that the nonprofit entity, the rural government entity, or the contractor for the rural government entity has completed similar Projects in the last three years (September 30, 2005 or later).

Proposals are due on Friday, September 19, 2008 by 5:00 p.m. and recommendations by the Advisory Council of the Texas Foundations Fund will be submitted to the Board of Directors at its regularly scheduled board meeting in October. Questions should be submitted in writing to Katherine Closmann by email at kclosmann@tsahc.org. To view the Texas Foundations Fund Guidelines, the full NOFA, and the Proposal Checklist, please go to www.tsahc.org.

TRD-200803529
David Long
President
Texas State Affordable Housing Corporation
Filed: July 9, 2008

♦ ♦ ♦

Department of Assistive and Rehabilitative Services

Noncompetitive Procurement: DARS Information Resources Division Assessment

The Department of Assistive and Rehabilitative Services (DARS) has requested a proposal from an independent consultant to perform an assessment of the DARS Information Resources Division. The consultant will assess and document the "As Is" state of the division and conduct a strengths, weaknesses, opportunities, and threats (SWOT) analysis.

DARS is not soliciting offers for this work.

The proposal has been requested in accordance with the Department of Information Resources (DIR) Go DIRect program. DARS anticipates entering into a contract with the consultant on or about August 15, 2008.

For further information, please contact Kevin Warren, Program Specialist, DARS, 4900 North Lamar Boulevard, Austin, Texas 78751, (512) 424-4523.

TRD-200803480
Sylvia F. Hardman
General Counsel
Department of Assistive and Rehabilitative Services
Filed: July 7, 2008

♦ ♦ ♦

Office of the Attorney General

Texas Health and Safety Code Settlement Notice

Notice is hereby given by the State of Texas of the following proposed revisions to the injunctive portions of a judgment rendered in a lawsuit brought under the Texas Health and Safety Code. Before the State may settle a judicial enforcement action under the Health and Safety Code, the State shall permit the public to comment in writing on the proposed judgment. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreed judgment if the comments disclose facts or considerations that indicate that the consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the Code.

Case Title and Court: *State of Texas v. La Joya Water Supply Corp.*, Cause No. GV400991; in the 53rd Judicial District Court, Travis County, Texas.

Nature of Defendant's Operations: Defendant operates a public drinking water system in Hidalgo and Starr Counties of Texas. Defendant's public drinking water system serves approximately 12,000 residents. The State initiated the suit to enforce the rules of the Texas Commission on Environmental Quality regarding the operation public drinking water systems. On April 29, 2004, the parties entered an Agreed Final Judgment, which provides for a permanent injunction ordering the Defendant to improve the system. On August 31, 2005, Defendant's water system was placed in the hands of a receiver, and on August 24, 2006, certain injunctive provisions in the Agreed Final Judgment were modified, based on changed circumstances.

Proposed Second Agreed Final Judgment and Modified Permanent Injunction: The parties now seek to file a second modification to the 2004 Agreed Final Judgment. The proposed changes would extend certain deadlines contained in the 2006 Modified Agreed Final Judgment and would acknowledge the completion of certain compliance objectives contained in the 2006 Modified Agreed Final Judgment.

For a complete description of the proposed settlement, the proposed Second Agreed Final Judgment and Modified Permanent Injunction should be reviewed. To request a copy, contact Tom Bohl at (512) 475-4228 or Melodie Cartwright at (512) 475-4034, send a request by facsimile to Tom Bohl, Assistant Attorney General, ATTN: Melodie Cartwright at (512) 320-0052, or mail a request to Tom Bohl, Assistant Attorney General, Office of the Texas Attorney General, P.O. Box 12548, Austin, Texas 78711-2548, ATTN: Melodie Cartwright. Written comments may be sent by facsimile to Tom Bohl, Assistant Attorney General, ATTN: Melodie Cartwright at (512) 320-0052, or by mail

to Tom Bohl, Assistant Attorney General, Office of the Texas Attorney General, P.O. Box 12548, Austin, Texas 78711-2548, ATTN: Melodie Cartwright. Written comments must be received within 30 days of publication of this notice to be considered.

For more information regarding this publication, contact Cindy Hodges, Agency Liaison, at (512) 936-1841.

TRD-200803498
Stacey Napier
Deputy Attorney General
Office of the Attorney General
Filed: July 8, 2008

♦ ♦ ♦

Coastal Coordination Council

Notice and Opportunity to Comment on Requests for Consistency Agreement/Concurrence Under the Texas Coastal Management Program

On January 10, 1997, the State of Texas received federal approval of the Coastal Management Program (CMP) (62 Federal Register pp. 1439-1440). Under federal law, federal agency activities and actions affecting the Texas coastal zone must be consistent with the CMP goals and policies identified in 31 TAC Chapter 501. Requests for federal consistency review were deemed administratively complete for the following project(s) during the period of June 27, 2008, through July 3, 2008. As required by federal law, the public is given an opportunity to comment on the consistency of proposed activities in the coastal zone undertaken or authorized by federal agencies. Pursuant to 31 TAC §§506.25, 506.32, and 506.41, the public comment period for this activity extends 30 days from the date published on the Coastal Coordination Council's web site. The notice was published on the web site on July 9, 2008. The public comment period for this project will close at 5:00 p.m. on August 8, 2008.

FEDERAL AGENCY ACTIONS:

Applicant: Sanchez Oil and Gas Corporation; Location: The project is located near Spindletop Ditch, approximately 7.22 miles southeast of Frigridge, Jefferson County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: MAPNAME, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 15; Easting: 375678; Northing: 3285571. Project Description: The applicant proposes to fill 3.766 acres of intermediate marsh to construct a 400-foot by 400-foot ring-leveed area for the purpose of preparing a well site to drill the Coronado West Prospect and a 90-foot by 90-foot access wing. Road access to this location will utilize existing roadways and levees. The entire drill site and access wing are located in jurisdictional wetlands. Board mats will be trucked in and laid on top of natural ground to create the drilling pad and access wing. Approximately 777 cubic yards of excavation will be required to construct the ring levees. The applicant proposes to mitigate for the proposed impacts by paying Edwin Arnaud, Inc. to place a portion of land within the Rose City Marsh into an environmental conservation easement. CCC Project No.: 08-0178-F1. Type of Application: U.S.A.C.E. permit application #SWG-2007-01455 is being evaluated under §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project may be conducted by the Railroad Commission of Texas under §401 of the Clean Water Act (33 U.S.C.A. §1344).

Pursuant to §306(d)(14) of the Coastal Zone Management Act of 1972 (16 U.S.C.A. §§1451 - 1464), as amended, interested parties are invited to submit comments on whether a proposed action is or is not consistent with the Texas Coastal Management Program goals and policies and whether the action should be referred to the Coastal Coordination Council for review.

Further information on the applications listed above, including a copy the consistency certifications for inspection, may be obtained from Tammy Brooks, Consistency Review Coordinator, Coastal Coordination Council, P.O. Box 12873, Austin, Texas 78711-2873, or tammy.brooks@glo.state.tx.us. Comments should be sent to Ms. Brooks at the above address or by fax to (512) 475-0680.

TRD-200803495
Larry L. Laine
Chief Clerk/Deputy Land Commissioner, General Land Office
Coastal Coordination Council
Filed: July 7, 2008

♦ ♦ ♦

Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §303.003 and §303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 07/14/08 - 07/20/08 is 18% for Consumer[1]/Agricultural/Commercial[2]/credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 07/14/08 - 07/20/08 is 18% for Commercial over $250,000.

[1]Credit for personal, family or household use.

[2]Credit for business, commercial, investment or other similar purpose.

TRD-200803497
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: July 8, 2008

♦ ♦ ♦

East Texas Council of Governments

Public Notice

The East Texas Council of Governments (ETCOG) is issuing a Request for Proposals (RFP) for Back Up Transportation Services for the following counties: Anderson, Camp, Cherokee, Gregg, Harrison, Henderson, Marion, Panola, Rains, Rusk, Smith, Upshur, Van Zandt and Wood. The RFP is available to view online at www.etcog.org. Proposals are due to ETCOG on August 26, 2008 at 5:00 p.m. CST. There will be a bidders conference July 25, 2008 at 10:00 a.m. CST.

NOTE: Any corrections, alterations or answers to questions concerning the RFP will be posted at the aforementioned web site. It is the responsibility of the proposer to review the web site periodically for corrections, alterations or answers to questions.

ETCOG is an Equal Opportunity Employer Auxiliary aids and services are available upon request. (903) 984-8641 or TDD (800) 725-2989.

TRD-200803477
David A. Cleveland
Executive Director
East Texas Council of Governments
Filed: July 3, 2008

♦ ♦ ♦

Texas Education Agency

Request for Alternate Assessments for Student Success Initiative

Description. The Texas Education Agency (TEA) is notifying test publishers that assessment instruments for the alternate assessment option of the Student Success Initiative (SSI) may be submitted for review. Texas Education Code (TEC), §28.0211, specifies the grade advancement requirements enacted by the 76th Texas Legislature, 1999, as the SSI. This initiative mandates that students must pass specific subject-area tests at specific grade levels on the statewide assessment in order to be promoted to the next grade. These requirements apply to reading at Grades 3, 5, and 8 and to mathematics at Grades 5 and 8. Grades 3 and 5 include reading and mathematics in both English and Spanish.

These testing requirements are part of an overall system of support for student academic achievement on grade level. The SSI is a comprehensive set of services for students, including informal and formal assessment of student needs and corresponding early intervention activities that address those needs; research-based instructional programs; targeted accelerated instruction informed by multiple testing opportunities; and a grade placement committee that decides, on an individual student basis, the most effective way to support a student's academic achievement and individual accelerated education plan. Further information on the SSI is available on the TEA website at www.tea.state.tx.us/student.assessment.

Program Requirements. The TEC allows a school district the option of using an alternate assessment in place of the Texas Assessment of Knowledge and Skills (TAKS) on the third testing opportunity. TEC, §28.0211(b), specifies: "A school district may administer an alternate assessment instrument to a student who has failed an assessment instrument specified under Subsection (a) on the previous two opportunities. Notwithstanding any other provision of this section, a student may be promoted if the student performs at grade level on an alternate assessment instrument under this subsection that is appropriate for the student's grade level and approved by the commissioner."

Under 19 TAC Chapter 101, Assessment, Subchapter BB, Commissioner's Rules Concerning the Student Success Initiative, §101.2011, Alternate Assessment, the commissioner of education shall adopt a list of alternate assessments that school districts may use on the third testing opportunity. The rule specifies the following program requirements.

(a) On the third testing opportunity, each school district and charter school may establish by local board policy a district-wide procedure to use a state-approved alternate assessment instead of the statewide assessment instrument specified in 19 TAC §101.2003(a) (relating to grade advancement testing requirements). The commissioner of education shall provide annually, to school districts and charter schools, a list of state-approved group-administered achievement tests certified by test publishers as meeting the requirements of TEC, §28.0211. This list shall include nationally recognized instruments for obtaining valid and reliable data, which demonstrate a student's competencies in the applicable subject at the appropriate grade level range. The district shall select only one test for each applicable grade and subject to be used under this section.

(b) The alternate assessment must be given during the period established in the assessment calendar to coincide with the date of the third administration of the statewide assessment.

(c) A company or organization scoring a test defined in 19 TAC §101.2011(a) shall send the test results to the school district for verification within 10 working days following receipt of the test materials from the school district and shall send a copy of those results to the TEA in a format specified by and on a schedule established by the TEA.

(d) To maintain the security and confidential integrity of group-administered achievement tests, school districts and charter schools shall follow the procedures for test security and confidentiality delineated in 19 TAC Chapter 101, Assessment, Subchapter C, Security and Confidentiality.

Both criterion-referenced tests (CRTs) and norm-referenced tests (NRTs) are eligible for inclusion on the commissioner's list of alternate assessments.

In addition to the program requirements listed previously, alternate assessments must meet the following requirements specified for group-administered achievement tests under TEC, §39.032: (1) the school district may not use the same form of an assessment instrument for more than three years (both CRTs and NRTs); (2) the standardization norms may not be more than six years old at the time the test is administered (NRTs only); and (3) standardization norms must be based on a national probability sample that meets accepted standards for educational and psychological testing (NRTs only).

The commissioner's list of alternate assessment instruments is expected to be made available to local school districts and charter schools no later than January 2009.

Selection Criteria. Each instrument adopted by the commissioner must meet the following criteria, and proposals from test publishers must address each of these criteria and include a copy of the instrument and the administrative materials to be used.

Reliability and Validity. The proposal must describe the reliability and validity data for the test in accordance with applicable educational testing standards, as set forth by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education. The proposal must include discussion of measurement error.

Curriculum Alignment and Match. The proposal must demonstrate, using an acceptable, industry-recognized methodology, how the assessment instrument aligns with and matches the domain of the Texas Essential Knowledge and Skills (TEKS) for the grade and subject area tested. TAKS Information Booklets, which show the alignment of the TAKS with the TEKS for each grade and subject, are available on the TEA website at www.tea.state.tx.us/student.assessment.

Comparable Standard. The proposal must provide a plan to establish a comparable "passing" performance standard to the TAKS passing standard. This plan must describe a method for providing this comparable standard (e.g., the equipercentile or equivalent passing standards method) in accordance with applicable educational testing standards. The plan must also provide for the comparable passing standard to be established and made available to schools no later than May 29, 2009.

Reporting. Each assessment instrument administered in accordance with TEC, §28.0211, must be scored and the results returned to the appropriate school district not later than 10 days after receipt of the test materials by the alternate assessment contractor. The contractor must also send a copy of those results to the TEA in a format specified by and on a schedule established by the TEA.

Security. A test publisher must ensure that any tests offered for the purposes of this application have not been publicly disclosed or otherwise released in a manner that could compromise the validity of the instrument. The proposal must describe the procedures that will be followed to ensure the security of the test form while used for this program.

Additional Features. The proposal may include any additional benefits to the State of Texas as a result of the proposer's specific plan for providing an alternate assessment.

The commissioner shall have the right to select any or none of the instruments submitted for review. This notice is not a guarantee that a test will be selected.

Deadline for Receipt of Proposals. Proposals must be submitted to Carla Morita, Budget and Operations Manager, Student Assessment Division, Texas Education Agency, 1701 North Congress Avenue, Suite 3-122A, Austin, Texas 78701, by 5:00 p.m. (Central Time), Monday, September 15, 2008, to be considered. To have an assessment instrument returned after review, a cover letter requesting its return must be submitted with the proposal.

Further information. For additional information contact Carla Morita at carla.morita@tea.state.tx.us.

TRD-200803513
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Filed: July 9, 2008

♦ ♦ ♦

Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (the Code), §7.075. Section 7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. Section 7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **August 18, 2008**. Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-1864 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on August 18, 2008**. Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that comments on the AOs shall be submitted to the commission in **writing**.

(1) COMPANY: Adelfo Hernandez dba 3H Auto Sales; DOCKET NUMBER: 2007-1479-AIR-E; IDENTIFIER: RN105308795; LOCATION: Grand Prairie, Tarrant County; TYPE OF FACILITY: used car lot; RULE VIOLATED: 30 Texas Administrative Code (TAC) §114.20(c)(1) and Texas Health and Safety Code (THSC), §382.085(b), by failing to equip the 1989 Ford Mustang with a three-way oxidation catalytic converter prior to offering it for sale; and 30 TAC §114.20(c)(2) and THSC, §382.085(b), by failing to maintain the required control systems in good operable condition; PENALTY: $450; ENFORCEMENT COORDINATOR: Cheryl Thompson, (817) 588-5800; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(2) COMPANY: AAMIR ENTERPRISES, INC dba Star Stop; DOCKET NUMBER: 2008-0577-PST-E; IDENTIFIER: RN101446771; LOCATION: Houston, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(2)(A) and the Code, §26.3475(a), by failing to provide proper release detection for the pressurized piping associated with the underground storage tanks (USTs); 30 TAC §334.50(b)(2)(A)(i)(III) and the Code, §26.3475(a), by failing to test the line leak detectors for performance and operational reliability; and 30 TAC §115.245(2) and THSC, §382.085(b), by failing to verify proper operation of the Stage II equipment; PENALTY: $4,576; ENFORCEMENT COORDINATOR: Wallace Myers, (512) 239-6580; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(3) COMPANY: ADVANCE PETROLEUM DISTRIBUTING COMPANY, INC. dba Automated Fueling 82; DOCKET NUMBER: 2008-0810-PST-E; IDENTIFIER: RN102485877; LOCATION: Fort Worth and South Lake, Tarrant County; TYPE OF FACILITY: fuel distributor; RULE VIOLATED: 30 TAC §115.221 and THSC, §382.085(b), by failing to control displaced vapors by a vapor control or a vapor balance system during the transfer of gasoline; PENALTY: $1,120; ENFORCEMENT COORDINATOR: Rajesh Acharya, (512) 239-0577; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(4) COMPANY: American Commodities, Inc.; DOCKET NUMBER: 2008-0754-WQ-E; IDENTIFIER: RN1054980361; LOCATION: Laredo, Webb County; TYPE OF FACILITY: used oil transfer and rail car cleaning; RULE VIOLATED: 30 TAC §281.25(a)(4) and 40 Code of Federal Regulations (CFR) §122.26(c), by failing to obtain authorization to discharge storm water associated with industrial activities; PENALTY: $1,800; ENFORCEMENT COORDINATOR: Steve Villatoro, (512) 239-4930; REGIONAL OFFICE: 1403 Seymour, Suite 2, Laredo, Texas 78040-8752, (956) 691-6611.

(5) COMPANY: Apple Springs Independent School District; DOCKET NUMBER: 2008-0510-MWD-E; IDENTIFIER: RN101607851; LOCATION: Trinity County; TYPE OF FACILITY: wastewater treatment system; RULE VIOLATED: 30 TAC §305.125(1), Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0014086001, Effluent Limitations and Monitoring Requirements Number 6, and the Code, §26.121(a), by failing to comply with the permitted effluent limitation for dissolved oxygen (DO); and 30 TAC §305.125(1) and TPDES Permit Number WQ0014086001, Other Requirements Number 7, by failing to submit a groundwater monitoring plan; PENALTY: $4,500; Supplemental Environmental Project (SEP) offset amount of $3,600 applied to Angelina Beautiful Clean ENFORCEMENT COORDINATOR: Lynley Doyen, (512) 239-1364; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1982, (409) 898-3838.

(6) COMPANY: Ash Grove Texas, L.P.; DOCKET NUMBER: 2008-0407-AIR-E; IDENTIFIER: RN100225978; LOCATION: Midlothian, Ellis County; TYPE OF FACILITY: portland cement manufacturing plant; RULE VIOLATED: 30 TAC §122.146(1) and (2) and THSC, §382.085(b), by failing to submit the required annual compliance certification; and 30 TAC §122.145(2)(A) - (C) and §122.146(1) and (2), and THSC, §382.085(b), by failing to timely submit the required deviation report; PENALTY: $16,725; SEP offset

amount of $6,690 applied to City of Fort Worth - "Mow Down Air Pollution" lawn mower exchange event; ENFORCEMENT COORDINATOR: Jorge Ibarra, (817) 588-5800; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(7) COMPANY: Axtell Water Supply Corporation; DOCKET NUMBER: 2008-0710-PWS-E; IDENTIFIER: RN101442648; LOCATION: Axtell, McLennan County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.45(b)(1)(D)(v), by failing to provide emergency power that will deliver water at a rate of 0.35 gallons per minute (gpm) per connection; 30 TAC §290.45(b)(1)(D)(iv) and THSC, §341.0315(c), by failing to provide a pressure tank capacity of 20 gallons per connection; and 30 TAC §290.42(b)(2)(C), by failing to provide a 16-mesh or finer corrosion-resistant screen; PENALTY: $687; ENFORCEMENT COORDINATOR: Epifanio Villareal, (210) 490-3096; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(8) COMPANY: Belvan Corp.; DOCKET NUMBER: 2007-1548-AIR-E; IDENTIFIER: RN100214022; LOCATION: Crockett County; TYPE OF FACILITY: gas plant; RULE VIOLATED: 30 TAC §101.10(e) and THSC, §382.085(b), by failing to submit a 2006 annual emissions inventory update; PENALTY: $3,000; ENFORCEMENT COORDINATOR: Aaron Houston, (409) 898-3838; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 76903-7013, (915) 655-9479.

(9) COMPANY: BP Amoco Chemical Company; DOCKET NUMBER: 2008-0628-AIR-E; IDENTIFIER: RN102536307; LOCATION: Texas City, Galveston County; TYPE OF FACILITY: chemical plant; RULE VIOLATED: 30 TAC §116.715(a), Permit Number 1176, Special Condition (SC) Number 1, and THSC, §382.085(b), by failing to maintain an emission rate below the maximum allowable emission limits; and 30 TAC §116.715(a), Permit Number 1176, SC Number 4B, 40 CFR §60.18(c)(2), and THSC, §382.085(b), by failing to operate with a flame present at all times; PENALTY: $10,000; ENFORCEMENT COORDINATOR: Jorge Ibarra, (817) 588-5800; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(10) COMPANY: Charles R. Brown; DOCKET NUMBER: 2008-0554-PST-E; IDENTIFIER: RN102011699; LOCATION: Avoca, Jones County; TYPE OF FACILITY: property with two inactive USTs; RULE VIOLATED: 30 TAC §334.47(a)(2), by failing to permanently remove from service, no later than 60 days after the prescribed upgrade implementation date, two USTs; PENALTY: $4,750; ENFORCEMENT COORDINATOR: Judy Kluge, (817) 588-5800; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (915) 698-9674.

(11) COMPANY: Chesapeake Energy Marketing, Inc.; DOCKET NUMBER: 2008-0684-WR-E; IDENTIFIER: RN105487706; LOCATION: Grand Prairie, Tarrant County; TYPE OF FACILITY: fracture drilling operation; RULE VIOLATED: 30 TAC §297.11 and the Code, §11.121, by failing to obtain a temporary water rights permit; PENALTY: $575; ENFORCEMENT COORDINATOR: Andrew Hunt, (512) 239-1203; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(12) COMPANY: City of Corpus Christi; DOCKET NUMBER: 2008-0399-MWD-E; IDENTIFIER: RN101610079; LOCATION: Nueces County; TYPE OF FACILITY: wastewater treatment collection system; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0010401006, Permit Conditions Number 2.g, and the Code, §26.121(a), by failing to prevent the unauthorized discharge of wastewater; PENALTY: $18,180; SEP offset amount of $14,544 applied to Coastal Bend Bays and Estuaries Program, Inc.; ENFORCEMENT COORDINATOR: Andrew Hunt, (512) 239-1203; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(13) COMPANY: Mamie Dell Baker dba Country Living Mobile Home Park; DOCKET NUMBER: 2008-0324-MWD-E; IDENTIFIER: RN101513307; LOCATION: Harrison County; TYPE OF FACILITY: wastewater treatment system; RULE VIOLATED: 30 TAC §305.65 and §305.125(2) and the Code, §26.121(a), by failing to maintain authorization for the discharge of wastewater; and 30 TAC §290.51(a)(3) and the Code, §5.702, by failing to pay the outstanding public health service fee; PENALTY: $11,660; ENFORCEMENT COORDINATOR: Craig Fleming, (512) 239-5506; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3756, (903) 535-5100.

(14) COMPANY: Chris Trout dba CTS C Store 1; DOCKET NUMBER: 2008-0394-PST-E; IDENTIFIER: RN101433456; LOCATION: Wylie, Collin County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(d)(1)(B)(ii) and the Code, §26.3475(c)(1), by failing to conduct reconciliation of inventory control records; 30 TAC §334.50(b)(2)(A)(i)(III) and the Code, §26.3475(a), by failing to test the line leak detectors; 30 TAC §334.50(b)(2) and the Code, §26.3475(a), by failing to provide proper release detection for the piping associated with the UST system; and 30 TAC §334.51(a)(6) and the Code, §26.3475(c)(2), by failing to ensure that all spill and overfill prevention devices are maintained in good operating condition; PENALTY: $7,230; ENFORCEMENT COORDINATOR: Wallace Myers, (512) 239-6580; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(15) COMPANY: DCP Midstream, LP; DOCKET NUMBER: 2008-0695-AIR-E; IDENTIFIER: RN100219955; LOCATION: Hansford County; TYPE OF FACILITY: gas plant; RULE VIOLATED: 30 TAC §113.1090, 40 CFR §63.6600(a), and THSC, §382.085(b), by failing to reduce formaldehyde (CH_2O) emissions by 76% or more or limit the concentration of CH_2O to 350 parts per billion or less at 15% oxygen; PENALTY: $2,575; ENFORCEMENT COORDINATOR: Cheryl Thompson, (817) 588-5800; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(16) COMPANY: DESI GROUP, INC. dba Fina Mart; DOCKET NUMBER: 2008-0444-PST-E; IDENTIFIER: RN102361060; LOCATION: Grand Prairie, Dallas County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.245(2) and THSC, §382.085(b), by failing to verify proper operation of the Stage II equipment; 30 TAC §115.242(1)(C) and THSC, §382.085(b), by failing to upgrade the Stage II equipment to onboard refueling vapor recovery compatible systems; 30 TAC §115.242(3)(A) and THSC, §382.085(b), by failing to maintain the Stage II vapor recovery system in proper operating condition; 30 TAC §334.45(c)(3)(A), by failing to install an emergency shutoff valve on each pressurized delivery or product line and ensure that it is securely anchored at the base of the dispenser; 30 TAC §334.49(c)(4) and the Code, §26.3475(d), by failing to have the cathodic protection system inspected and tested for operability and adequacy of protection; 30 TAC §334.50(b)(1)(A) and the Code, §26.3475(c)(1), by failing to ensure that all USTs are monitored in a manner which will detect a release; 30 TAC §334.50(b)(2) and the Code, §26.3475(a), by failing to provide release detection for the piping associated with the USTs; 30 TAC §334.50(b)(2)(A)(i)(III) and the Code, §26.3475(a), by failing to test the line leak detectors at least once per year for performance and operational reliability; and 30 TAC §334.50(d)(1)(B)(ii) and the Code, §26.3475(c)(1), by failing to conduct reconciliation of detailed inventory control records; PENALTY: $12,038; ENFORCEMENT COORDINATOR: Judy Kluge, (817) 588-5800; REGIONAL OF-

FICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(17) COMPANY: DONALD C. MOORE & SONS, INC. dba Handi Stop 3; DOCKET NUMBER: 2008-0404-PST-E; IDENTIFIER: RN102653029; LOCATION: George West, Live Oak County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.49(a) and the Code, §26.3475(d), by failing to provide proper corrosion protection for the UST system; 30 TAC §334.50(b)(1)(A) and the Code, §26.3475(c)(1), by failing to monitor USTs for releases; and 30 TAC §334.48(c), by failing to conduct effective manual or automatic inventory control procedures for all USTs; PENALTY: $13,750; ENFORCEMENT COORDINATOR: Rajesh Acharya; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(18) COMPANY: Elm Creek Water Supply Corporation; DOCKET NUMBER: 2008-0485-PWS-E; IDENTIFIER: RN101217818; LOCATION: Moody, McLennan County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.43(e), by failing to provide an intruder-resistant fence; 30 TAC §290.46(m)(4), by failing to maintain distribution system lines, water storage and pressure maintenance facilities, and related appurtenances in a watertight condition; and 30 TAC §290.45(b)(1)(D)(i) and §290.45(f)(4) and THSC, §341.0315(c), by failing to provide a total production capacity of 0.6 gpm per connection; PENALTY: $472; ENFORCEMENT COORDINATOR: Stephen Thompson, (512) 239-2558; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(19) COMPANY: Equistar Chemicals, LP; DOCKET NUMBER: 2008-0591-AIR-E; IDENTIFIER: RN100221662; LOCATION: Corpus Christi, Nueces County; TYPE OF FACILITY: industrial organic chemical manufacturing company; RULE VIOLATED: 30 TAC §111.111(a)(4) and §116.115(b)(2)(F) and (c), Air Permit Number 4682B, General Conditions and SC Number 27(C), and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $6,000; SEP offset amount of $2,400 applied to Beautify Corpus Christi Association - Cleanup of Illegal Dump Sites; ENFORCEMENT COORDINATOR: John Muennink, (361) 825-3100; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(20) COMPANY: Friedman Recycling of El Paso LP; DOCKET NUMBER: 2008-0255-MSW-E; IDENTIFIER: RN105231880; LOCATION: El Paso, El Paso County; TYPE OF FACILITY: municipal solid waste recycling; RULE VIOLATED: 30 TAC §37.921 and §328.5(d), by failing to establish and maintain financial assurance for the closure of a recycling facility; 30 TAC §328.5(h), by failing to have a fire prevention and suppression plan; 30 TAC §328.5(c), by failing to submit a written closure cost estimate; and 30 TAC §330.7(a), by failing to obtain a permit, registration or alternative compliance for the processing of recyclable material that contains more than incidental amounts of non-recyclable waste; PENALTY: $13,872; ENFORCEMENT COORDINATOR: Clinton Sims, (512) 239-6933; REGIONAL OFFICE: 401 East Franklin Avenue, Suite 560, El Paso, Texas 79901-1206, (915) 834-4949.

(21) COMPANY: Gulf Coast Waste Disposal Authority; DOCKET NUMBER: 2008-0375-MWD-E; IDENTIFIER: RN102183340; LOCATION: Friendswood, Harris County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 TAC §305.125(4), TPDES Permit Number WQ0011571001, Permit Conditions Number 2.g, and the Code, §26.121(a), by failing to prevent the unauthorized discharge of wastewater; PENALTY: $7,810; SEP offset amount of $6,248 applied to Galveston Bay Foundation - "Marsh Mania"; ENFORCEMENT COORDINATOR: Heather Brister, (254) 751-0335; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(22) COMPANY: Hanson Pipe & Precast, Inc.; DOCKET NUMBER: 2008-0594-WQ-E; IDENTIFIER: RN104168356; LOCATION: Lorena, McLennan County; TYPE OF FACILITY: concrete products batch plant; RULE VIOLATED: the Code, §26.121, by failing to prevent the unauthorized discharge of waste laden storm water; PENALTY: $750; ENFORCEMENT COORDINATOR: Andrew Hunt, (512) 239-1203; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(23) COMPANY: International Wood, LLC; DOCKET NUMBER: 2008-0236-AIR-E; IDENTIFIER: RN100215458; LOCATION: Weslaco, Hidalgo County; TYPE OF FACILITY: drapery hardware, blinds, and shades manufacturing plant; RULE VIOLATED: 30 TAC §122.146(2) and THSC, §382.085(b), by failing to submit a permit compliance certification; PENALTY: $2,375; ENFORCEMENT COORDINATOR: Samuel Short, (512) 239-5363; REGIONAL OFFICE: 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(24) COMPANY: City of Joaquin; DOCKET NUMBER: 2005-1747-MWD-E; IDENTIFIER: RN102095437; LOCATION: Joaquin, Shelby County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(5), TPDES Permit Number 12718001, Permit Conditions Number 2(g), and the Code, §26.121(a), by failing to prevent unauthorized discharges; 30 TAC §305.125(1) and §319.11(d) and TPDES Permit Number 12718001, Monitoring and Reporting Requirements Number 2, by failing to install and maintain the appropriate staff gauge; 30 TAC §305.125(11)(C) and §319.7(a) and TPDES Permit Number 12718001, Monitoring and Reporting Requirements Number 3(c), by failing to maintain complete records of monitoring activities; 30 TAC §305.125(5) and §317.3(e)(4)(C) and TPDES Permit Number 12718001, Operational Requirements Number 1, by failing to ensure that all systems of collection, treatment, and disposal are properly operated and maintained; 30 TAC §305.125(5) and TPDES Permit Number 12718001, Operational Requirements Number 1, by failing to implement adequate process control testing; 30 TAC §305.125(1) and TPDES Permit Number 12718001, Other Requirements Number 8(g), by failing to install soil moisture monitoring sensors; 30 TAC §305.125(12) and §319.7(c) and TPDES Permit Number 12718001, Permit Conditions Number 1(a), by failing to report the correct analytical results on the Discharge Monitoring Report (DMR); 30 TAC §305.125(1) and §305.126(a) and TPDES Permit Number 12718001, Operational Requirements Numbers 1 and 8(a), by failing to obtain authorization to commence construction of additional treatment and/or collection facilities upon reaching 90% of the permitted daily average flow; 30 TAC §305.125(5) and TPDES Permit Number 12718001, Operational Requirements Number 1, by failing to ensure that all systems of collection, treatment, and disposal are operated and maintained; 30 TAC §317.4(a)(8) and §317.7(i) and TPDES Permit Number 12718001, Operational Requirements Number 1, by failing to have an atmospheric vacuum breaker installed on the hose bib; 30 TAC §305.125(1) and (17) and TPDES Permit Number 12718001, Sludge Provisions Section II Subsection F, by failing to submit the annual sludge reports; 30 TAC §305.125(1) and (11)(B) and TPDES Permit Number 12718001, Sludge Provisions Section II Subsection E.6, by failing to maintain records of the agronomic loading rate; 30 TAC §305.125(5), TPDES Permit Number 12718001, Operational Requirements Number 1, Interim Effluent Limitations and Monitoring Requirements Number 4, Permit Conditions Number 2(g), and the Code, §26.121(a), by failing to prevent the discharge and accumulation of sludge in the receiving stream; 30 TAC §317.3(b)(1) and (e)(5) and TPDES Permit Number 12718001, Operational Requirements Number 1, by failing to ensure that all

systems of collection, treatment, and disposal are properly operated and maintained; and 30 TAC §30.350(d), by allowing an unlicensed person to operate the facility; PENALTY: $92,040; SEP offset amount of $73,632 applied to Texas Association of Resource Conservation and Development Areas, Inc. ("RC&D") - Water or Wastewater Treatment Assistance; ENFORCEMENT COORDINATOR: Pamela Campbell, (512) 239-4493; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(25) COMPANY: City of Maud; DOCKET NUMBER: 2008-0603-MWD-E; IDENTIFIER: RN103138202; LOCATION: Bowie County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0014025001, Effluent Limitations and Monitoring Requirements Numbers 1, 2, and 3, and the Code, §26.121(a), by failing to comply with the permitted effluent limitations for five-day biochemical oxygen demand (BOD_5), pH, total suspended solids (TSS) and total chlorine residual; PENALTY: $9,400; SEP offset amount of $7,520 applied to RC&D - Unauthorized Trash Dump Clean-Up; ENFORCEMENT COORDINATOR: Lynley Doyen, (512) 239-1364; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3756, (903) 535-5100.

(26) COMPANY: City of McGregor; DOCKET NUMBER: 2008-0587-MWD-E; IDENTIFIER: RN101609220; LOCATION: McLennan County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0010219002, Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a)(1), by failing to comply with permit effluent limits for TSS; and 30 TAC §305.125(17) and TPDES Permit Number WQ0010219002, Sludge Provisions, by failing to submit the annual sludge report; PENALTY: $3,507; ENFORCEMENT COORDINATOR: Heather Brister, (254) 751-0335; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(27) COMPANY: Melrose Construction, Inc.; DOCKET NUMBER: 2008-0457-WQ-E; IDENTIFIER: RN105464515; LOCATION: Glen Rose, Somervell County; TYPE OF FACILITY: residential construction site; RULE VIOLATED: 30 TAC §281.25(a)(4) and 40 CFR §122.26(c), by failing to develop and implement a storm water pollution prevention plan and obtain authorization coverage to discharge storm water associated with construction activities; PENALTY: $1,500; ENFORCEMENT COORDINATOR: Jorge Ibarra, (817) 588-5800; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(28) COMPANY: Grady W. Mosley; DOCKET NUMBER: 2008-0415-PST-E; IDENTIFIER: RN101892875; LOCATION: Troup, Smith County; TYPE OF FACILITY: two inactive USTs; RULE VIOLATED: 30 TAC §334.47(a)(2), by failing to permanently remove from service, no later than 60 days after the prescribed implementation date, two USTs; 30 TAC §334.7(d)(3), by failing to notify the agency of any change or additional information regarding USTs; and 30 TAC §334.22(a) and the Code, §5.702, by failing to pay outstanding UST fees and associated late fees; PENALTY: $6,300; ENFORCEMENT COORDINATOR: Steven Lopez, (512) 239-1896; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3756, (903) 535-5100.

(29) COMPANY: Near Bore Resources, Inc.; DOCKET NUMBER: 2008-0312-MLM-E; IDENTIFIER: RN105170518; LOCATION: New London, Rusk County; TYPE OF FACILITY: pyrolysis plant; RULE VIOLATED: 30 TAC §328.60(a), by failing to obtain a scrap tire storage site registration; 30 TAC §328.63(c), by failing to obtain a scrap tire facility registration; 30 TAC §335.62 and §335.78(g)(1) and 40 CFR §262.11(a), by failing to perform hazardous waste determinations on wastes generated by the facility; and 30 TAC §335.6(c), by failing to notify the Executive Director as a generator of industrial waste; PENALTY: $26,000; ENFORCEMENT COORDINATOR: Ross Fife, (512) 239-2541; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3756, (903) 535-5100.

(30) COMPANY: City of Port Arthur; DOCKET NUMBER: 2007-0787-MWD-E; IDENTIFIER: RN101608024; LOCATION: Jefferson County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1) and TPDES Permit Number 10364010, Operational Requirements Number 1, by failing to properly maintain the collection system; 30 TAC §305.125(5) and TPDES Permit Number 10364010, Operational Requirements Number 1, by failing to ensure that all systems of collection, treatment, and disposal are properly operated and maintained; 30 TAC §305.125(1), TPDES Permit Number 10364010, Permit Conditions Number 2(g), and the Code, §26.121(a), by failing to prevent the unauthorized discharge of wastewater; and 30 TAC §305.125(17) and §319.7(a)(4) and (c), and TPDES Permit Number 10364010, Monitoring and Reporting Requirements Numbers 1 and 3(b), by failing to accurately complete the DMRs and have them readily available for review; PENALTY: $13,860; SEP offset amount of $6,000 applied to Wastewater Treatment Assistance; SEP offset amount of $5,088 applied to Jefferson County Pleasure Island Shoreline Stabilization; ENFORCEMENT COORDINATOR: Pamela Campbell, (512) 239-4493; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(31) COMPANY: Safety-Kleen Systems, Inc.; DOCKET NUMBER: 2008-0620-IWD-E; IDENTIFIER: RN103896387; LOCATION: Denton County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0004336000, Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a), by failing to comply with the permitted effluent limitations for chemical oxygen demand and total organic carbon; and 30 TAC §305.125(17) and §319.7(d) and TPDES Permit Number WQ0004336000, Monitoring and Reporting Requirements Number 1, by failing to timely submit monitoring results; PENALTY: $4,070; ENFORCEMENT COORDINATOR: Lauren Smitherman, (512) 239-5223; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(32) COMPANY: San Antonio Water System; DOCKET NUMBER: 2008-0379-MWD-E; IDENTIFIER: RN102182789; LOCATION: Bexar County; TYPE OF FACILITY: wastewater treatment system; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0010137004, Effluent Limitations and Monitoring Requirements Numbers 1, 2, and 5, and the Code, §26.121(a), by failing to comply with the permitted effluent limitations for DO, pH, and TSS; PENALTY: $7,400; ENFORCEMENT COORDINATOR: Lauren Smitherman, (512) 239-5223; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(33) COMPANY: Sunoco, Inc. (R&M); DOCKET NUMBER: 2008-0190-AIR-E; IDENTIFIER: RN102888328; LOCATION: La Porte, Harris County; TYPE OF FACILITY: petrochemical manufacturing plant; RULE VIOLATED: 30 TAC §116.115(c), TCEQ Air Permit Number 5572B, SC Number 1, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $4,850; ENFORCEMENT COORDINATOR: Nadia Hameed, (713) 767-3500; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(34) COMPANY: Teen Challenge of Texas fka Teen Challenge of South Texas; DOCKET NUMBER: 2008-0426-MWD-E; IDENTIFIER: RN102179124; LOCATION: Nueces County; TYPE OF FACILITY: wastewater system; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0011689001, Effluent Limitations and Monitoring Requirements Numbers 1 and 6, and the Code, §26.121(a), by

failing to comply with permit effluent limits for DO, BOD_5, and TSS; PENALTY: $4,500; ENFORCEMENT COORDINATOR: Heather Brister, (254) 751-0335; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(35) COMPANY: The Dow Chemical Company; DOCKET NUMBER: 2008-0478-AIR-E; IDENTIFIER: RN100225945; LOCATION: Freeport, Brazoria County; TYPE OF FACILITY: chemical manufacturing plant; RULE VIOLATED: 30 TAC §§101.20(1), 101.221(a), and 116.115(c), New Source Review Air Permit Number 834, SC Numbers 1 and 3, 40 CFR §60.18(c)(2) and (e), and THSC, §382.085(b), by failing to prevent unauthorized emissions; and 30 TAC §101.20(3) and §116.715(a), Flexible Air Permit Number 20432 and PSD-TX-994M1, SC III-1, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $20,000; SEP offset amount of $8,000 applied to Houston-Galveston AERCO's Clean Cities/Clean Vehicles Program; ENFORCEMENT COORDINATOR: Trina Grieco, (210) 490-3096; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(36) COMPANY: Troy T. Hunt Management Corporation; DOCKET NUMBER: 2008-0492-WQ-E; IDENTIFIER: RN105110472; LOCATION: Midland, Midland County; TYPE OF FACILITY: residential construction site; RULE VIOLATED: 30 TAC §281.25(a)(4), TPDES General Permit Number TXR150000, Part III Section F.2.(a)(ii), and 40 CFR §122.26(c), by failing to properly select, install, or maintain erosion and sediment control measures for the site; and 30 TAC §281.25(a)(4), TPDES General Permit Number TXR150000, Part III Section F.7, and 40 CFR §122.26(c), by failing to maintain structural controls and best management practices; PENALTY: $1,650; ENFORCEMENT COORDINATOR: Andrew Hunt, (512) 239-1203; REGIONAL OFFICE: 3300 North A Street, Building 4, Suite 107, Midland, Texas 79705-5404, (915) 570-1359.

(37) COMPANY: Tyler County; DOCKET NUMBER: 2007-1355-MSW-E; IDENTIFIER: RN101999969; LOCATION: Woodville, Tyler County; TYPE OF FACILITY: waste transfer station; RULE VIOLATED: 30 TAC §330.121(a) and Site Development Plan Sections (C)(ii), (C)(iv)(c), (J), and Site Operating Plan Section (iii)(a)(4), by failing to comply with the approved site development plan and site operating plans; 30 TAC §330.125(a), by failing to maintain a copy of the registration and associated documents at the facility; 30 TAC §330.221(c), by failing to comply with fire protection requirements; and 30 TAC §330.201(b), by failing to apply for a modification to the site operating plan to incorporate the 2006 rule revisions by the required deadline; PENALTY: $6,300; SEP offset amount of $5,040 applied to RC&D - Wastewater Treatment Assistance; ENFORCEMENT COORDINATOR: John Shelton, (512) 239-2563; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3756, (903) 535-5100.

(38) COMPANY: Valero Refining-Texas, L.P.; DOCKET NUMBER: 2008-0712-AIR-E; IDENTIFIER: RN100219310; LOCATION: Houston, Harris County; TYPE OF FACILITY: petroleum refinery; RULE VIOLATED: 30 TAC §116.115(c), Air Permit Number 2501A, SC Number 1, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $19,800; SEP offset amount of $7,920 applied to Houston-Galveston AERCO's Clean Cities/Clean Vehicles Program; ENFORCEMENT COORDINATOR: Nadia Hameed, (713) 767-3500; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

TRD-200803499

Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: July 8, 2008

♦ ♦ ♦

Notice of Water Quality Applications

The following notices were issued during the period of July 2, 2008 through July 8, 2008.

The following require the applicants to publish notice in a newspaper. Public comments, requests for public meetings, or requests for a contested case hearing may be submitted to the Office of the Chief Clerk, Mail Code 105, P.O. Box 13087, Austin, Texas 78711-3087, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THE NOTICE.

INFORMATION SECTION

242 LLC has applied for a renewal of Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0014414001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 900,000 gallons per day. The facility will be located approximately 4,600 feet southeast of the intersection of State Highway 242 and Donwick Drive in Montgomery County, Texas.

301 LONE OAK PARTNERS LTD has applied for a new permit, proposed TPDES Permit No. WQ0014870001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 252,000 gallons per day. The facility will be located approximately 2,800 feet south of Cypress Creek, north of Farm-to-Market Road 1960, 3,600 feet west of Cypresswood Drive in Harris County, Texas.

CALTEX HOLDING LP which operates the CalTex Mill (an idle integrated pulp and paper mill), has applied to the Texas Commission on Environmental Quality (TCEQ) for a renewal of TPDES Permit No. WQ0001160000, which authorizes the discharge of treated storm water, landfill leachate, and treated sanitary sewage on an intermittent and flow variable basis via Outfall 001 for the interim phase; treated process wastewater, utility wastewater, treated storm water, landfill leachate, and treated sanitary sewage at a daily average flow not to exceed 6,500,000 gallons per day via Outfall 001 for the final phase; and storm water on an intermittent and flow variable basis via Outfalls 002, 003, and 004. The draft permit authorizes the discharge of treated storm water, landfill leachate, and treated sanitary sewage on an intermittent and flow variable basis via Outfall 001; and storm water on an intermittent and flow variable basis via Outfalls 002, 003, and 004. The facility is located at 18511 Beaumont Highway, north of Old Highway 90, between Sheldon Road and the San Jacinto River in the City of Sheldon, Harris County, Texas.

CITY OF OYSTER CREEK has applied for a renewal of TPDES Permit No. WQ0011837001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 500,000 gallons per day. The facility is located approximately 1.6 miles southeast of the intersection of State Highway 332 and Farm-to-Market Road 523, at the intersection of State Highway 332 and the U.S. Corps of Engineers Flood Control Levee on the west side of the levee in Brazoria County, Texas.

HILL COUNTRY CAMP has applied for a new permit, proposed TPDES Permit No. WQ0014832001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 25,000 gallons per day. The facility will be located at 1319 Harper Road in Kerrville County, Texas.

LOCHINVAR GOLF CLUB has applied for a new permit, proposed TPDES Permit No. WQ0014891001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 5,000 gallons per day. The facility is located at 2000 Farrell Road approximately 2,100 feet east-southeast of the intersection of Hardy Road and Farrell Road and 2.3 miles east-northeast of the intersection of Interstate Highway 45 and Kuykendahl Road in Harris County, Texas. Authorization to discharge was previously permitted by expired Permit No. WQ0012141001.

RICETEC INC has applied for a renewal of TPDES Permit No. WQ0014068001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 25,000 gallons per day. The facility is located at 1925 Farm-to-Market Road 2917, approximately 2,640 feet north of the intersection of Farm-to-Market Road 2917 and Farm-to-Market 2403 in Brazoria County, Texas.

SAN LEON MUNICIPAL UTILITY DISTRICT has applied for a renewal of TPDES Permit No. WQ0011546001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 950,000 gallons per day. The facility is located in the northeast corner of the intersection of Avenue L and 27th Street in San Leon and approximately 2,000 feet north of Salt Bayou and 5,000 feet northwest of Dickinson Bayou in Galveston County, Texas.

TERRA VERDE UTILITY COMPANY LLC has applied for a new permit, proposed TPDES Permit No. WQ0014901001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 10,000 gallons per day. The facility was previously permitted under TPDES Permit No. WQ0012402001, which expired March 1, 2008. The facility is located at 22602 Hegar Road, approximately 2 miles north of the intersection of Farm-to-Market Road 2920 and Hegar Road in Waller County, Texas.

THE KANSAS CITY SOUTHERN RAILWAY COMPANY which operates Kansas City Southern Railway Port Arthur Facility; a facility which provides light maintenance, fueling, and general servicing of diesel electric locomotives used for railroad transportation, has applied for a renewal of TPDES Permit No. WQ0002289000, which authorizes the discharge of process wastewater and storm water at a daily average dry weather flow not to exceed 4,000 gallons per day via Outfall 001. The facility is located at 548 West 5th Street, bounded on the north by West Proctor Street, on the west by the Martin Luther King, Jr. Bridge (Highway 82), and the east by the Jefferson County Hurricane Levee, in the City of Port Arthur, Jefferson County, Texas.

If you need more information about these permit applications or the permitting process, please call the TCEQ Office of Public Assistance, toll free, at 1-800-687-4040. General information about the TCEQ can be found at our web site at www.tceq.state.tx.us. Si desea información en Español, puede llamar al 1-800-687-4040.

TRD-200803524
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: July 9, 2008

♦ ♦ ♦

Texas Facilities Commission

Request for Proposals #303-8-10683

The Texas Facilities Commission (TFC), on behalf of the Department of Family and Protective Services, announces the issuance of Request for Proposals (RFP) #303-8-10683. TFC seeks a 5 or 10 year lease of approximately 10,246 square feet of office space in Lubbock, Lubbock County, Texas.

The deadline for questions is July 25, 2008 and the deadline for proposals is August 1, 2008 at 3:00 p.m. The anticipated award date is August 20, 2008. TFC reserves the right to accept or reject any or all proposals submitted. TFC is under no legal or other obligation to execute a lease on the basis of this notice or the distribution of an RFP. Neither this notice nor the RFP commits TFC to pay for any costs incurred prior to the award of a grant.

Parties interested in submitting a proposal may obtain information by contacting TFC Purchaser Sandy Williams at (512) 475-0453. A copy of the RFP may be downloaded from the Electronic State Business Daily at: *http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=77462*.

TRD-200803510
Kay Molina
General Counsel
Texas Facilities Commission
Filed: July 8, 2008

♦ ♦ ♦

Texas Health and Human Services Commission

Correction of Error

The Texas Health and Human Services Commission proposed the repeal of §§371.212 - 371.214 and new §371.212 and §371.214 in the July 4, 2008, issue of the *Texas Register* (33 TexReg 5131). There is a typographical error in the fax number listed in the Public Comment section of the preamble of the proposal. The correct fax number for comments on this proposal is (512) 833-6487. The error was made by the submitting agency. Texas Health and Human Services Commission, Office of Inspector General will extend its comment period for 30 days after the date of publication of this Correction of Error, and will accept public comment on the proposal through August 18, 2008. No changes were made to the original text of the proposed repeal and new rules submitted for adoption.

A notice of hearing with the correct fax number will be posted on the Texas Health and Human Services Commission's (www.hhsc.state.tx.us) website and in this issue of the *Texas Register.*

TRD-200803522
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: July 9, 2008

♦ ♦ ♦

Notice of Final Reimbursement Rate for Small, State-operated Intermediate Care Facilities for Persons with Mental Retardation

Final Rate. As the single state agency for the state Medicaid program, the Texas Health and Human Services Commission (HHSC) adopted the following interim per diem reimbursement rate for small, state-operated Intermediate Care Facilities for Persons with Mental Retardation, including facilities operated by the Texas Department of Aging and Disability Services: $340.99. The final rate is effective September 1, 2007.

Hearing. HHSC conducted a hearing on May 19, 2008, to receive public comment on the proposed reimbursement rate. The hearing was held in accordance with Title 1 of the Texas Administrative Code §355.105(g), which requires that public hearings be held on proposed reimbursement rates before such rates are approved by HHSC. Notice of the hearing was published in the May 2, 2008, issue of the *Texas*

Register (33 TexReg 3679). No persons attended the hearing or provided written or oral comments.

Methodology and Justification. The final rate was determined in accordance with the rate setting methodology codified at Texas Administrative Code Title 1, Part 15, Chapter 355, Subchapter D, §355.456(e), relating to Reimbursement Rates.

TRD-200803521
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: July 9, 2008

♦ ♦ ♦

Notice of Public Hearing

Texas Health and Human Services Commission

Office of Inspector General

Friday, August 1, 2008, at 1:30 p.m.

Public Hearing Room

Department of Aging and Disability Services

701 W. 51st Street

Austin, Texas 78751

Hearing. The Texas Health and Human Services Commission, Office of Inspector General, will conduct a public hearing on August 1, 2008, to receive comments on the proposed repeal of §§371.212 - 371.214 and proposed new §371.212 and §371.214 of Title 1, Part 15, Chapter 371, Subchapter C of the Texas Administrative Code. The proposal was published in the July 4, 2008, issue of the *Texas Register* (33 TexReg 5131). Any interested person may appear and offer comments or statements, either orally or in writing; however, questioning of commenters will be reserved exclusively to the Texas Health and Human Services Commission, Office of the Inspector General (OIG) or its staff as may be necessary to ensure a complete record. While any person with pertinent comments or statements will be granted an opportunity to present them during the course of the hearing, OIG reserves the right to restrict statements in terms of time or repetitive content. Organizations, associations, or groups are encouraged to present their commonly held views or similar comments through a representative member where possible. Persons with disabilities who have special needs and who plan to attend the meeting should contact David Stegall of the Department of Aging and Disability Services at (512) 438-3542.

Written Comments. Any interested person may submit written comments by fax, mail or hand delivery. The mailing address is P.O. Box 85200, Austin, Texas 78708-5200. The fax number is (512) 833-6487. The fax number for written comments listed in the preamble of the proposal was incorrect. A related Correction of Error giving the correct fax number for receipt of written comments is being published in this issue of the *Texas Register*.

TRD-200803530
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: July 9, 2008

♦ ♦ ♦

Public Notice

The Texas Health and Human Services Commission announces its intent to submit Transmittal Number 08-013, Amendment Number 817, to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendment is effective April 1, 2008.

The purpose of this amendment is to provide assurance to CMS that the State of Texas complies with the Medicaid Integrity Program, outlined in sections 1936 and 1902(a)(69) of the Social Security Act. The purpose of the Medicaid Integrity Program is to ensure accountability in health and human services programs by reviewing the actions of Medicaid service providers and service recipients to identify, communicate, and correct fraud, waste, and abuse. Among the activities supporting this stated purpose are: 1) the analysis and prediction of patterns of service provision and consumption; 2) oversight of policies and legal processes; 3) review and investigation of claim and payment activity; 4) identification of inappropriate payments; 5) pursuit of overpayment recovery, imposition of legal sanctions and remedies; and 6) education of Medicaid Program participants.

Texas complies with sections 1936 and 1902(a)(69) of the Social Security Act with active participation by various entities, including but not limited to: the Health and Human Services Commission's (HHSC) Office of Inspector General; the Office of the Attorney General's Medicaid Fraud Control Unit; HHSC's monitoring, compliance, and evaluation components within the Medicaid/CHIP Division; the Texas Department of Aging and Disability Services; and the Texas Medicaid Healthcare Partnership.

The proposed amendment is estimated to result in no additional annual aggregate expenditures.

To obtain copies of the proposed amendment, interested parties may contact Tamela Griffin by mail at Medicaid and CHIP Division, Policy Development, Texas Health and Human Services Commission, P.O. Box 13247, mail code H370, Austin, Texas 78708-5200; by telephone at (512) 491-1341; by facsimile at (512) 491-1953; or by e-mail at Tamela.griffin@hhsc.state.tx.us.

TRD-200803468
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: July 3, 2008

♦ ♦ ♦

Department of State Health Services

Licensing Actions for Radioactive Materials

The Department of State Health Services has taken actions regarding Licenses for the possession and use of radioactive materials as listed in the tables. The subheading "Location" indicates the city in which the radioactive material may be possessed and/or used. The location listing "Throughout Texas" indicates that the radioactive material may be used on a temporary basis at job sites throughout the state.

NEW LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Arlington	Ellahi Heart Clinic	L06166	Arlington	00	06/20/08

AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Amarillo	Texas Oncology PA DBA Texas Oncology Cancer Center-Amarillo	L06149	Amarillo	01	06/20/08
Amarillo	Cardiology Center of Amarillo LLP	L05736	Amarillo	09	06/16/08
Angleton	Isotherapeutics Group LLC	L05969	Angleton	07	06/27/08
Arlington	Cardiology Partners LLP	L05999	Arlington	02	06/22/08
Arlington	GE Healthcare	L05693	Arlington	06	06/24/08
Austin	Austin Heart PA	L04623	Austin	59	06/17/08
Austin	ARA Imaging	L05862	Austin	35	06/17/08
Austin	Heart Hospital IV LP DBA Heart Hospital of Austin	L05215	Austin	29	06/16/08
Baytown	Baytown Imaging Center LP	L05772	Baytown	04	06/17/08
Big Spring	Alon USA LP	L04950	Big Spring	11	06/25/08
Conroe	CHCA Conroe LP DBA Conroe Regional Medical Center	L01769	Conroe	77	06/16/08
Conroe	Sadler Clinic/Montgomery Co Mgmt Company	L04899	Conroe	26	06/17/08
Corpus Christi	Triad Isotopes, Inc. DBA Clinical Nuclear Services	L05368	Corpus Christi	13	06/26/08
Dallas	Medical Edge Healthcare Group PA DBA Verity Radiation Therapy	L06135	Dallas	00	06/24/08
Dallas	Mallinckrodt, Inc	L03580	Dallas	60	06/26/08
Dallas	North Texas Heart Center PA	L04608	Dallas	34	06/22/08
Deer Park	Shell Oil Products US DBA Deer Park Refining Limited Partnership	L04554	Deer Park	24	06/24/08
Dripping Springs	Pavetex Engineering and Testing, Inc.	L05533	Dripping Springs	07	06/18/08
Harlingen	Valley Baptist Medical Center	L01909	Harlingen	67	06/24/08
Houston	Framo Engineering Houston	L05867	Houston	02	06/13/08
Houston	Kellogg Brown & Root, Inc.	L03660	Houston	16	06/13/08
Houston	Methodist Health Centers DBA Methodist Willowbrook Hospital	L05472	Houston	27	06/12/08
Houston	Betabatt, Inc.	L05961	Houston	02	06/17/08
Houston	National Oilwell Varco LP Rolligon Division	L06094	Houston	01	06/17/08
Houston	The Methodist Hospital	L00457	Houston	159	06/19/08
Houston	Nuclear Imaging Services	L05775	Houston	42	06/24/08
Huntsville	Huntsville Memorial Hospital	L02822	Huntsville	16	06/25/08
Katy	St. Catherine Health & Wellness Center	L05310	Katy	16	06/25/08
Kerrville	Sid Peterson Memorial Hospital DBA Peterson Regional Medical Center	L01722	Kerrville	37	06/25/08
Longview	Eastman Chemicals Company Tx Operations	L00301	Longview	109	06/16/08
Lubbock	Isorx Texas Ltd.	L05284	Lubbock	23	06/13/08
Lubbock	Texas Tech University Health Sciences Center	L01869	Lubbock	87	06/13/08
Lubbock	Texas Tech University Environmental Health	L01536	Lubbock	85	06/25/08
Midland	Midland County Hospital District DBA Midland Memorial Hospital	L00728	Midland	90	06/24/08
Mt Pleasant	Titus County Memorial Hospital	L02921	Mt Pleasant	27	06/12/08

AMENDMENTS TO EXISTING LICENSES ISSUED (CONTINUED)

Location	Name	License #	City	Amend-ment #	Date of Action
Plainview	Methodist Hospital Plainview DBA Covenant Hospital Plainview	L02493	Plainview	29	06/24/08
Port Arthur	Smith and Thome Cardiovascular Consultants	L05743	Port Arthur	05	06/12/08
San Angelo	Shannon Clinic	L04216	San Angelo	43	06/27/08
San Antonio	ACA SA Ltd. DBA Sendero Imaging and Treatment Center	L05567	San Antonio	14	06/16/08
San Antonio	Central Cardiovascular Institute of San Antonio	L04892	San Antonio	19	06/16/08
San Antonio	Methodist Healthcare System of San Antonio DBA Methodist Hospital	L00594	San Antonio	244	06/18/08
San Antonio	VHS San Antonio Imaging Partners LP DBA Baptist M&S Imaging Centers	L04506	San Antonio	67	06/12/08
San Antonio	Bionumerik Pharmaceuticals Inc	L05226	San Antonio	12	06/23/08
San Antonio	Texas Cancer Clinic	L05786	San Antonio	10	06/26/08
San Antonio	VHS San Antonio Partners LLC DBA Baptist Health System	L00455	San Antonio	177	06/25/08
Stafford	Sugarland Veterinary Specialists PC	L05903	Stafford	05	06/27/08
Stephenville	Stephenville Medical and Surgical Clinic	L05309	Stephenville	13	06/16/08
Throughout Tx	MACTEC Engineering & Consulting, Inc.	L05490	Addison	12	06/25/08
Throughout Tx	Qal-Tek Associates LLC	L05965	Austin	04	06/23/08
Throughout Tx	Numed Imaging Centers, Inc.	L05762	Cleburne	08	06/13/08
Throughout Tx	Berry Fabricators	L01575	Corpus Christi	54	06/13/08
Throughout Tx	APAC - Texas Inc Texas Bitulithic Division	L04503	Dallas	13	06/13/08
Throughout Tx	Sterigenics US Inc.	L03851	Ft Worth	36	06/17/08
Throughout Tx	GSS Laboratories & Specialty Testing LLC	L05994	Granbury	01	06/24/08
Throughout Tx	Protechnics Environmental	L04477	Houston	18	06/13/08
Throughout Tx	Radiographic Specialists, Inc.	L02742	Houston	59	06/13/08
Throughout Tx	Metco	L03018	Houston	187	06/23/08
Throughout Tx	Weldsonix, Inc.	L05718	Houston	40	06/24/08
Throughout Tx	Monitoring Services	L04501	Houston	11	06/24/08
Throughout Tx	RJR Engineering LTD LLP	L05416	Houston	05	06/25/08
Throughout Tx	Fugro Consultants, Inc.	L00058	Houston	52	06/27/08
Throughout Tx	Thrubit LLC	L06030	Houston	05	06/27/08
Throughout Tx	K. C. Engineering	L06061	Marble Falls	02	06/16/08
Throughout Tx	T. C. Inspection, Inc.	L05833	Oyster Creek	31	06/24/08
Throughout Tx	Conam Inspection & Engineering, Inc.	L05010	Pasadena	142	06/12/08
Throughout Tx	Conam Inspection & Engineering, Inc.	L05010	Pasadena	144	06/27/08
Throughout Tx	Techcorr USA LLC	L05972	Pasadena	47	06/12/08
Throughout Tx	Techcorr USA LLC	L05972	Pasadena	48	06/26/08
Throughout Tx	Conam Inspection & Engineering, Inc.	L05010	Pasadena	143	06/25/08
Throughout Tx	Midwest Inspection Services	L03120	Perryton	109	06/16/08
Throughout Tx	Midwest Inspection Services	L03120	Perryton	110	06/27/08
Throughout Tx	Arias & Associates, Inc.	L04964	San Antonio	31	06/13/08
Throughout Tx	Kleinfelder	L01351	Waco	60	06/27/08
Throughout Tx	Frontera Materials, Inc.	L04830	Weslaco	15	06/24/08
Tyler	East Texas Medical Center	L00977	Tyler	140	06/27/08
Waco	Lehigh Cement Company	L01087	Waco	22	06/13/08

RENEWAL OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Desoto	Vishu Lammata MD PA	L05311	Desoto	11	06/24/08
El Paso	Guillermo A Pinzon MD PA	L04277	El Paso	16	06/24/08
Throughout Tx	Bandy & Associates, Inc.	L05402	Houston	04	06/17/08

TERMINATIONS OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Mt Pleasant	Luminant Mining Company LLC	L06087	Mt Pleasant	02	06/13/08
Mesquite	Lone Star HMA LP DBA Womens Hosp.@ Dallas Reg. Med. Ctr.	L02733	Mesquite	40	06/27/08

In issuing new licenses, amending and renewing existing licenses, or approving license exemptions, the Department of State Health Services (department), Radiation Safety Licensing Branch, has determined that the applicant has complied with the applicable provisions of Title 25 Texas Administrative Code (TAC) Chapter 289, regarding radiation control. In granting termination of licenses, the department has determined that the licensee has complied with the applicable decommissioning requirements of 25 TAC Chapter 289. In denying the application for a license, license renewal or license amendment, the department has determined that the applicant has not met the applicable requirements of 25 TAC Chapter 289.

This notice affords the opportunity for a hearing on written request of a person affected within 30 days of the date of publication of this notice. A person affected is defined as a person who demonstrates that the person has suffered or will suffer actual injury or economic damage and, if the person is not a local government, is (a) a resident of a county, or a county adjacent to the county, in which radioactive material is or will be located, or (b) doing business or has a legal interest in land in the county or adjacent county. A person affected may request a hearing by writing Richard A. Ratliff, Radiation Program Officer, Department of State Health Services, Radiation Material Licensing - MC 2835, PO Box 149347, Austin, Texas 78714-9347. For information call (512) 834-6688.

TRD-200803481
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: July 7, 2008

♦ ♦ ♦

Texas Department of Housing and Community Affairs

Notice of Public Hearing on Section 8 Program 2009 Annual Plan

Section 511 of Title V of the Quality Housing and Work Responsibility Act of 1998 (P.L. 205-276) requires the Texas Department of Housing and Community Affairs (the Department) to prepare a 2009 Annual Plan covering operations of the Section 8 Program. Title 24, §903.17 of the Code of Federal Regulations requires that the Department conduct a public hearing regarding that plan. The Department will hold a public hearing to receive comments for the development of the Department's 2009 Annual Plan. The hearing will take place at the following time and location:

September 10, 2008

Texas Department of Housing and Community Affairs

221 East 11th Street, Room 116

Austin, Texas 78701

1:30 p.m. - 4:30 p.m.

The proposed 2009 Annual Plan and all supporting documentation are available to the public for viewing at the Department's main office, 221 East 11th Street, Attention: Section 8 Program, Austin, Texas on weekdays during the hours of 8:00 a.m. until 4:30 p.m. The proposed plan will also be available for viewing on the Department's website at www.tdhca.state.tx.us/sec8.htm.

Questions or requests for additional information may be directed to Willie Faye Hurd, Section 8 Program Manager, Community Affairs Division at whurd@tdhca.state.tx.us or by mail at P.O. Box 13941, Austin, Texas 78711-3941, (512) 475-3892. Comments must be received by 5:00 p.m. Friday, September 12, 2008.

Persons who intend to appear at the hearing and express their comments are invited to contact Willie Faye Hurd in writing in advance of the hearing. Any interested persons unable to attend the hearing may submit their comments in writing to Willie Faye Hurd prior to the date scheduled for the hearing. Individuals who require a language interpreter for the hearing should contact Willie Faye Hurd at least three days prior to the hearing date. Personas que hablan español y requieren un intérprete, favor de llamar a Jorge Reyes al siguiente número (512) 475-4577 por lo menos tres días antes de la junta para hacer los preparativos apropiados.

Individuals who require auxiliary aids or services for this hearing should contact Gina Esteves at (512) 475-3943 or Relay Texas at 1-800-735-2989 at least 2 days before the scheduled hearing so that appropriate arrangements can be made.

TRD-200803509
Michael G. Gerber
Executive Director
Texas Department of Housing and Community Affairs
Filed: July 8, 2008

♦ ♦ ♦

Texas Lottery Commission

Instant Game Number 1028 "Super Set for Life II"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1028 is "SUPER SET FOR LIFE II". The play style is "key number match with auto win".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1028 shall be $20.00 per ticket.

1.2 Definitions in Instant Game No. 1028.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, DOLLAR BILL SYMBOL, STAR SYMBOL, LIFE SYMBOL, $20.00, $25.00, $30.00, $40.00, $100, $500, $1,000, $2,000, $10,000 and $500K/YR SYMBOL.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1028 - 1.2D

PLAY SYMBOL	CAPTION
1	ONE
2	TWO
3	THR
4	FOR
5	FIV
6	SIX
7	SVN
8	EGT
9	NIN
10	TEN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
20	TWY
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET
29	TWNI
30	TRTY
31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX
37	TRSV
38	TRET
39	TRNI
40	FRTY
DOLLAR BILL SYMBOL	AUTO
STAR SYMBOL	WINALL
LIFE SYMBOL	WIN
$20.00	TWENTY
$25.00	TWY FIV
$30.00	THIRTY

$40.00	FORTY
$100	ONE HUND
$500	FIV HUND
$1,000	ONE THOU
$2,000	TWO THOU
$10,000	10 THOU
$500K/YR	500K/YR

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There will be a four (4)-digit "security number" which will be individually boxed and randomly placed within the number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Low-Tier Prize - A prize of $20.00.

G. Mid-Tier Prize - A prize of $25.00, $30.00, $40.00, $100 or $500.

H. High-Tier Prize - A prize of $1,000, $2,000, $10,000 or $500K/YR (for 15 years not to exceed $7,500,000).

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) bar code which will include a four (4) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the ten (10) digit Validation Number. The bar code appears on the back of the ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1028), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 001 and end with 025 within each pack. The format will be: 1028-0000001-001.

K. Pack - A pack of "SUPER SET FOR LIFE II" Instant Game tickets contains 025 tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). The packs will alternate. One will show the front of ticket 001 and back of 025 while the other fold will show the back of ticket 001 and front of 025.

L. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "SUPER SET FOR LIFE II" Instant Game No. 1028 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "SUPER SET FOR LIFE II" Instant Game is determined once the latex on the ticket is scratched off to expose 55 (fifty-five) play symbols. If the player matches any of YOUR NUMBERS play symbols to any of the WINNING NUMBERS play symbols, the player wins the PRIZE shown for that number. If the player reveals a "DOLLAR BILL" play symbol, the player wins PRIZE shown instantly. If the player reveals a "STAR" play symbol, the player wins all 25 PRIZES shown. If the player reveals a "LIFE" play symbol, the player wins $500,000 a year for 15 years not to exceed $7,500,000 total. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 55 (fifty-five) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 55 (fifty-five) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 55 (fifty-five) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 55 (fifty-five) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork

on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets will not have identical play data, spot for spot.

B. No five or more matching non-winning prize symbols on a ticket.

C. No duplicate WINNING NUMBERS play symbols on a ticket.

D. No duplicate non-winning YOUR NUMBERS play symbols on a ticket.

E. The STAR (win all) play symbol will only appear on intended winning tickets as dictated by the prize structure.

F. The LIFE (annuity prize) play symbol will only appear with the $500K/YR prize symbol and both symbols will only appear on the four winning tickets as dictated by the prize structure.

G. Non-winning prize symbols will never be the same as the winning prize symbol(s).

H. No prize amount in a non-winning spot will correspond with the YOUR NUMBERS play symbol (i.e. 20 and $20).

2.3 Procedure for Claiming Prizes.

A. To claim a "SUPER SET FOR LIFE II" Instant Game prize of $20.00, $25.00, $30.00, $40.00, $100 or $500, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not required to pay a $25.00, $30.00, $40.00, $100 or $500 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "SUPER SET FOR LIFE II" Instant Game prize of $1,000, $2,000 or $10,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. To claim a "SUPER SET FOR LIFE II" top level prize of $500,000 per year (for 15 years not to exceed $7,500,000 total), the claimant must sign the winning ticket and present it at Texas Lottery Commission headquarters in Austin, Texas. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly

D. When claiming a "SUPER SET FOR LIFE II" Instant Game prize of $500,000 per year (for 15 years not to exceed $7,500,000), the claimant will receive his prize:

1. Annually via direct deposit to the winner's account. With this plan, upon validation of the prize, a payment of $500,000 less any taxes and/or other offsets or mandatory withholdings required by law, will be made once a year on the first business day of the anniversary month of the claim. Annual payments will be made for a period of 15 years or a total of 15 annual payments to reach the total maximum payment of $7,500,000.

2. If a payment falls on a holiday or weekend, the payment will be made on the following business day.

E. As an alternative method of claiming a "SUPER SET FOR LIFE II" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

F. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General;

3. delinquent in reimbursing the Texas Health and Human Services Commission for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

G. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "SUPER SET FOR LIFE II" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "SUPER SET FOR LIFE II" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 7,200,000 tickets in the Instant Game No. 1028. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1028 - 1.2E

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$20	432,000	16.67
$25	792,000	9.09
$30	720,000	10.00
$40	288,000	25.00
$100	93,000	77.42
$500	8,700	827.59
$1,000	3,360	2,142.86
$2,000	600	12,000.00
$10,000	30	240,000.00
$500K/YR	4	1,800,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.08. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1028 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1028, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200803478
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: July 3, 2008

♦ ♦ ♦

Instant Game Number 1098 "Jewels of the Nile"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1098 is "JEWELS OF THE NILE". The play style is "key number match with win all".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1098 shall be $5.00 per ticket.

1.2 Definitions in Instant Game No. 1098.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, PALM TREE SYMBOL, 10X SYMBOL, EYE SYMBOL, $5.00, $10.00, $15.00, $20.00, $50.00, $100, $200, $2,000 and $50,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1098 - 1.2D

PLAY SYMBOL	CAPTION
1	ONE
2	TWO
3	THR
4	FOR
5	FIV
6	SIX
7	SVN
8	EGT
9	NIN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
20	TWY
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET
29	TWNI
30	TRTY
31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX
37	TRSV
38	TRET
39	TRNI
40	FRTY
PALM TREE SYMBOL	AUTO
10X SYMBOL	WINX10
EYE SYMBOL	WINALL
$5.00	FIVE$
$10.00	TEN$
$15.00	FIFTN
$20.00	TWENTY

$50.00	FIFTY
$100	ONE HUND
$200	TWO HUND
$2,000	TWO THOU
$50,000	50 THOU

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There will be a four (4)-digit "security number" which will be individually boxed and randomly placed within the number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Low-Tier Prize - A prize of $5.00, $10.00, $15.00 or $20.00.

G. Mid-Tier Prize - A prize of $25.00, $50.00, $100 or $200.

H. High-Tier Prize - A prize of $2,000 or $50,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) bar code which will include a four (4) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the ten (10) digit Validation Number. The bar code appears on the back of the ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1098), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 001 and end with 075 within each pack. The format will be: 1098-0000001-001.

K. Pack - A pack of "JEWELS OF THE NILE" Instant Game tickets contains 075 tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). The packs will alternate. One will show the front of ticket 001 and back of 075 while the other fold will show the back of ticket 001 and front of 075.

L. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "JEWELS OF THE NILE" Instant Game No. 1098 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "JEWELS OF THE NILE" Instant Game is determined once the latex on the ticket is scratched off to expose 45 (forty-five) Play Symbols. If a player matches any of YOUR NUMBERS to any of the WINNING NUMBERS, the player wins the PRIZE shown for that number. If the player reveals a "palm tree" play symbol, the player wins the PRIZE shown for that symbol instantly. If a player reveals a "10X" symbol, the player wins 10 TIMES the PRIZE shown for that symbol. If the player reveals an "eye" play symbol, the player wins ALL TWENTY PRIZES INSTANTLY! No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 45 (forty-five) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 45 (forty-five) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 45 (forty-five) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 45 (forty-five) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets in a pack will not have identical play data, spot for spot.

B. The "10X" (10 times multiplier) and "EYE" (win all) play symbols will only appear on intended winning tickets and only as dictated by the prize structure.

C. The "PALM" (auto win) play symbol will never appear more than once on a ticket.

D. No four or more matching non-winning prize symbols on a ticket.

E. No duplicate WINNING NUMBERS play symbols on a ticket.

F. No duplicate non-winning YOUR NUMBERS play symbols on a ticket.

G. Non-winning prize symbols will never be the same as the winning prize symbol(s).

H. When the "EYE" (win all) play symbol appears, there will be no occurrence of any of YOUR NUMBERS play symbols matching any WINNING NUMBER play symbol.

I. No prize amount in a non-winning spot will correspond with the YOUR NUMBERS play symbol (i.e. 5 and $5).

2.3 Procedure for Claiming Prizes.

A. To claim a "JEWELS OF THE NILE" Instant Game prize of $5.00, $10.00, $15.00, $20.00, $25.00, $50.00, $100 or $200, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not required to pay a $25.00, $50.00, $100 or $200 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "JEWELS OF THE NILE" Instant Game prize of $2,000 or $50,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "JEWELS OF THE NILE" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General;

3. delinquent in reimbursing the Texas Health and Human Services Commission for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "JEWELS OF THE NILE" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "JEWELS OF THE NILE" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 6,000,000 tickets in the Instant Game No. 1098. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1098 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$5	480,000	12.50
$10	680,000	8.82
$15	80,000	75.00
$20	100,000	60.00
$25	80,000	75.00
$50	80,000	75.00
$100	4,000	1,500.00
$200	2,500	2,400.00
$2,000	250	24,000.00
$50,000	12	500,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.98. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1098 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1098, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200803479
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: July 3, 2008

♦ ♦ ♦

Texas Parks and Wildlife Department

Notice of Proposed Real Estate Transaction and Opportunity for Public Comment

Land Exchange and Conservation Easement - Bandera and Medina Counties

On August 21, 2008, the Texas Parks and Wildlife Commission (the Commission) will consider the transfer of approximately 110 acres of the Hill Country State Natural Area (HCSNA) in Bandera and Medina counties to an adjoining landowner in exchange for 210 acres adjoining HCSNA in another location. Under the agreement, the adjoining landowner also will place approximately 700 additional acres adjoining HCSNA under a conservation easement. The meeting will start at 9:00 a.m. in the Brown Education Center at the Houston Zoo, 6200 Golf Course Drive, Houston, Texas. Before taking action, the Commission will take public comment regarding the proposed transaction. Pub-

lic comment may be submitted to Corky Kuhlmann, Land Conservation, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744, by e-mail to corky.kuhlmann@tpwd.state.tx.us, or in person at the meeting.

TRD-200803523
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Filed: July 9, 2008

♦ ♦ ♦

Notice of Proposed Real Estate Transaction and Opportunity for Public Comment

Land Exchange - Presidio County

On August 21, 2008, the Texas Parks and Wildlife Commission (the Commission) will consider the transfer of approximately 502 acres at Big Bend Ranch State Park (BBRSP) to an adjoining landowner in exchange for approximately 1,434 acres, resulting in the elimination of five inholding tracts within BBRSP boundaries and a net increase in park acreage. The meeting will start at 9:00 a.m. in the Brown Education Center at the Houston Zoo, 6200 Golf Course Drive, Houston, Texas. Before taking action, the Commission will take public comment regarding the proposed transaction. Public comment may be submitted to Ted Hollingsworth, Land Conservation, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744, by e-mail to ted.hollingsworth@tpwd.state.tx.us, or in person at the meeting.

TRD-200803525
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Filed: July 9, 2008

♦ ♦ ♦

Notice of Proposed Real Estate Transaction and Opportunity for Public Comment

Conveyance of Easement - Tarrant County

On August 21, 2008, the Texas Parks and Wildlife Commission (the Commission) will consider granting an easement to Barnett Gathering, LP, to install an oil and gas pipeline across Texas Parks and Wildlife Department's property in Tarrant County. In exchange, Barnett Gathering will renovate a hatchery pond on the property for use as an angler recruitment venue. The meeting will start at 9:00 a.m. in the Brown Education Center at the Houston Zoo, 6200 Golf Course Drive, Houston, Texas. Before taking action, the Commission will take public comment regarding the proposed transaction. Public comment may be submitted to Corky Kuhlmann, Land Conservation, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744, by e-mail to corky.kuhlmann@tpwd.state.tx.us, or in person at the meeting.

TRD-200803526
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Filed: July 9, 2008

♦ ♦ ♦

Notice of Proposed Real Estate Transaction and Opportunity for Public Comment

Conveyance of Easement - Aransas County

On August 21, 2008, the Texas Parks and Wildlife Commission (the Commission) will consider granting an easement to the Lavaca Improvement District for the installation of underground water and wastewater lines traversing Goose Island State Park in Aransas County. The meeting will start at 9:00 a.m. in the Brown Education Center at the Houston Zoo, 6200 Golf Course Drive, Houston, Texas. Before taking action, the Commission will take public comment regarding the proposed transaction. Public comment may be submitted to Ted Hollingsworth, Land Conservation, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744, by e-mail to ted.hollingsworth@tpwd.state.tx.us, or in person at the meeting.

TRD-200803527
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Filed: July 9, 2008

♦ ♦ ♦

Notice of Proposed Real Estate Transaction and Opportunity for Public Comment

Land Sale - Harris County

On August 21, 2008, the Texas Parks and Wildlife Commission (the Commission) will consider a cash offer above appraised value for land and facilities on approximately one acre in La Porte, Harris County, currently serving as a regional headquarters location for the State Parks Division. The meeting will start at 9:00 a.m. in the Brown Education Center at the Houston Zoo, 6200 Golf Course Drive, Houston, Texas. Before taking action, the Commission will take public comment regarding the proposed transaction. Public comment may be submitted to Ted Hollingsworth, Land Conservation, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744, by e-mail to ted.hollingsworth@tpwd.state.tx.us, or in person at the meeting.

TRD-200803528
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Filed: July 9, 2008

♦ ♦ ♦

Public Utility Commission of Texas

Announcement of Application for State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on July 2, 2008, for a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Managed Services, Inc. for a State-Issued Certificate of Franchise Authority, Project Number 35847 before the Public Utility Commission of Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All inquiries should reference Project Number 35847.

TRD-200803506

Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 8, 2008

♦ ♦ ♦

Notice of a Joint Petition for Declaratory Order

Notice is given to the public of a petition for declaratory order with the Public Utility Commission of Texas on June 27, 2008.

Docket Style and Number: Joint Petition of Southwestern Public Service Company and Golden Spread Electric Cooperative, Inc. for a Declaratory Order, Docket Number 35820.

The Application: Southwestern Public Service Company (SPS) and Golden Spread Electric Cooperative, Inc. (Golden Spread) (collectively, Petitioners) filed a joint petition for declaratory order concerning the Replacement Power Sales Agreement (RPSA) that will supply capacity and energy to meet the electric needs of the Golden Spread member cooperatives who provide retail service in SPS electric service territories and certainty for SPS regarding the Texas Stipulation, which sets forth specific conditions under which SPS may enter into contracts assigning system average costs to wholesale contracts.

SPS seeks a declaratory order finding that: (1) entering into the RPSA was reasonable and prudent; (2) the sale of capacity and energy by SPS to Golden Spread at system average costs as provided in the RPSA is reasonable and will not cause incremental costs to be imputed to such sales in future retail base rate and fuel proceedings; and (3) the RPSA is consistent with the terms of the Texas Stipulation.

Persons who wish to intervene in the proceeding or comment upon the action sought should contact the Public Utility Commission of Texas, P.O. Box 13326, Austin, Texas 78711-3326, or call the commission's Customer Protection Division at (512) 936-7120 or (888) 782-8477. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) at 1-800-735-2989. All correspondence should refer to Docket Number 35820.

TRD-200803484
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 7, 2008

♦ ♦ ♦

Notice of Application for Approval of Transaction Under PURA §39.158

Notice is given to the public of an application for approval of the sale, transfer, merger, or affiliation of electric generation facilities filed with the Public Utility Commission of Texas (commission) on June 30, 2008, pursuant to the Public Utility Regulatory Act, Texas Utility Code Ann. §§14.101, 39.154, and 39.158 (Vernon 2007 & Supp. 2007) (PURA).

Docket Style and Number: Application of Duke Energy Corporation and Catamount Energy Corporation Pursuant to §39.158 of the Public Utility Regulatory Act, Docket Number 35836.

The Application: Duke Energy Corporation (Duke) and Catamount Energy Corporation (Catamount) filed an application for approval of the proposed merger between DEGS Wind Vermont, Inc. (Merger Sub), a wholly-owned indirect subsidiary of Duke, and Catamount with the merged entity to be known as Catamount Energy Corporation. As a result of the transaction, Catamount Energy Corporation will become an indirect subsidiary of Duke. Although Merger Sub does not have any generation ownership in the Electric Reliability Council of Texas (ERCOT) region, its ultimate parent company, Duke, through its subsidiaries, owns a gas-fired cogeneration facility in ERCOT and expects to have two wind turbine facilities in operation within the next twelve months. Catamount has direct and indirect ownership interests in the following generation facilities in ERCOT: Sweetwater Wind 1, LLC; Sweetwater Wind 2, LLC; Sweetwater Wind 3, LLC; Sweetwater Wind 4, LLC; and Sweetwater Wind 5, LLC.

Duke has ownership interests in a total of 852.55 MW that is located in, or capable of delivery to ERCOT, and is expected to be operational within the next twelve months. Catamount owns and controls 563.1 MW of installed wind generation capacity located in, or capable of delivery of electricity to ERCOT. Following the transaction, the newly affiliated companies will, directly or indirectly, own or control 1,415.65 MW of installed generation capacity in ERCOT, which represents 1.6% of the total installed generation capacity located in, or capable of delivering electricity to, ERCOT.

Under PURA §39.158, the Applicants are required to obtain commission approval before closing the transaction if the electricity to be offered for sale in the relevant power region will exceed one percent of the total electricity for sale in the relevant power region. The commission shall approve the transaction unless the commission finds that the transaction results in a violation of PURA §39.154. Under §39.154, a power generation company may not own and control more than 20% of the installed generation capacity located in, or capable of delivering electricity to a power region. The Applicants have stated that, since the newly affiliated entities will own and control 1,415.65 MW of installed generation capacity within ERCOT, this will not exceed the 20% limitation.

Persons who wish to intervene in or comment upon this application should notify the Public Utility Commission of Texas, P.O. Box 13326, Austin, Texas 78711-3326. Further information may also be obtained by calling the Public Utility Commission at (512) 936-7120 or (888) 782-8477. Hearing- and speech impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Docket Number 35836.

TRD-200803483
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 7, 2008

♦ ♦ ♦

Notice of Application for Relinquishment of a Certificate of Operating Authority

On July 1, 2008, Peoples Telecommunications, Inc. filed an application with the Public Utility Commission of Texas (commission) to relinquish its certificate of operating authority (COA) granted in COA Certificate Number 50022. Applicant intends to relinquish its certificate.

The Application: Application of Peoples Telecommunications, Inc. to Relinquish its Certificate of Operating Authority, Docket Number 35845.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than July 23, 2008. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at

(512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 35845.

TRD-200803505
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 8, 2008

♦ ♦ ♦

Notice of Intent to Implement Minor Rate Changes Pursuant to P.U.C. Substantive Rule §26.171

Notice is given to the public of Eastex Telephone Cooperative, Inc. (Eastex) application filed with the Public Utility Commission of Texas (commission) on July 1, 2008, for approval of a minor rate change pursuant to P.U.C. Substantive Rule §26.171.

Tariff Control Title and Number: Application of Eastex Telephone Cooperative, Inc. for Approval of a Minor Rate Change Pursuant to P.U.C. Substantive Rule §26.171; Tariff Control Number 35844.

The Application: Eastex filed an application to increase access line rates or their equivalent by 10% for residential and business customers, and implement a late payment fee charge for qualifying residential customers. The proposed effective date for the proposed rate changes is November 1, 2008. The estimated annual revenue increase recognized by Eastex is $390,020 or less than 5% of Eastex's gross annual intrastate revenues. Eastex has 29,361 access lines (residence and business) in service in the state of Texas.

If the commission receives a complaint(s) relating to this application signed by the lesser of 5% or 1,500 of the affected local service customers to which this application applies by October 1, 2008, the application will be docketed. The 5% limitation will be calculated based upon the total number of customers of record as of the calendar month preceding the commission's receipt of the complaint(s).

Persons wishing to comment on this application should contact the Public Utility Commission of Texas by October 1, 2008. Requests to intervene should be filed with the commission's Filing Clerk at P.O. Box 13326, Austin, Texas 78711-3326, or you may call the commission at (512) 936-7120 or toll-free 1-800-735-2989. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Tariff Control Number 35844.

TRD-200803482
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 7, 2008

♦ ♦ ♦

Public Notice of Request for Comment Regarding Retail Electric Providers Disclosures to Customers

The staff of the Public Utility Commission of Texas (commission) request comments regarding a strawman rule which alters Retail Electric Provider responsibilities and disclosures to customers. Project Number 35768, *Rulemaking Relating to Retail Electric Providers Disclosures to Customers* has been assigned to this proceeding.

The commission staff strawman rule has been filed in Central Records under Project Number 35768. The commission requests interested persons file written comments on this strawman rule.

Responses may be filed by submitting 16 copies to the commission's Filing Clerk, Public Utility Commission of Texas, 1701 North Congress Avenue, P.O. Box 13326, Austin, Texas 78711-3326 by Thursday, July 17, 2008 and reply comments may be filed by Thursday, July 24, 2008. All responses should reference Project Number 35768.

Questions concerning the comments or this notice should be referred to Shawnee Claiborn-Pinto, Competitive Markets Division, (512) 936-7388. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136.

TRD-200803520
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 9, 2008

♦ ♦ ♦

Public Notice of Request for Comments on the Use of Demand Ratchets

The staff of the Public Utility Commission of Texas (Staff) is interested in receiving comments for Project Number 35855, *Request for Comments on the Use of Demand Ratchets*.

Staff requests that interested persons file responses to the following questions regarding the use of demand ratchets as a tool in the rate-setting process for electric utilities:

1. In establishing the electricity rates paid by certain customers, is the use of demand ratchets as they are currently employed in commission-approved tariffs an appropriate rate-design tool? Please explain your response thoroughly, and include in your comments a discussion of the theoretical foundations for the use of demand ratchets in the rate-setting process and a description and comparison of the various methodologies used to implement ratchet mechanisms.

2. If demand ratchets are employed, how should the commission establish the appropriate percentage level(s) at which to set the ratchets? To which customers should demand ratchets apply and what are the criteria that determine these customers?

3. If demand ratchets are employed, what is the appropriate demand threshold (5 kW, 10 kW, etc.) that would subject a customer to the ratchet mechanism? Should the threshold be different for different companies or different customers and, if so, what are the criteria that determine the appropriate threshold?

4. Should the use of ratchet mechanisms be considered in a generic rulemaking proceeding or on a company-by-company basis during rate-case proceedings?

5. If demand ratchets are used to set rates for Texas electricity customers, on what basis and through what process should exemptions to specific customers be granted?

6. If certain customers are exempted from the use of demand ratchets, how and from which customers and rate classes should the shortfall in revenues be recovered, if at all?

Responses may be filed by submitting 16 copies to the commission's Filing Clerk, Public Utility Commission of Texas, 1701 North Congress Avenue, P.O. Box 13326, Austin, Texas 78711-3326 by August 8, 2008. All responses should reference Project Number 35855. This notice is not a formal notice of proposed rulemaking, but the parties' responses to the questions will assist the commission in developing commission policies or determining the necessity for a related rulemaking.

Questions concerning this notice should be referred to Darryl Tietjen ((512) 936-7436; darryl.tietjen@puc.state.tx.us) or Rich Lain ((512) 936-7454; rich.lain@puc.state.tx.us) in the Rate Regulation Division.

TRD-200803507
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 8, 2008

♦ ♦ ♦

The Texas A&M University System

Award of Request for Proposal

RFP 08-0005 Consulting Services: Natural Gas Campus Transmission Delivery and Distribution System Evaluation

In compliance with the provisions of Chapter 2254, Subchapter B, Texas Government Code, The Texas A&M University System furnishes this notice of award of request for proposal. A request for proposal notice was published in the *Texas Register* on December 21, 2007 (32 TexReg 9871).

Awarded Firm:

EN Engineering

7135 Janes Avenue

Woodridge, Illinois 60517

Description of Activities: Provider shall evaluate the condition and routing of the existing Atmos-owned on-campus natural gas distribution system, including operational and financial considerations. Additionally, this consulting firm will be evaluating options for an alternate natural gas transmission delivery system to serve the Texas A&M campus in College Station, Texas.

Not-to-Exceed Cost: $162,000

Contract Period: July 1, 2008 through January 15, 2009

TRD-200803493
Vickie Burt Spillers
Executive Secretary to the Board
The Texas A&M University System
Filed: July 7, 2008

♦ ♦ ♦

The University of Texas System

Request for Applications Concerning the Mid-Career Teacher Recruitment Program, 2008-2009

Filing Authority. The availability of grant funds is authorized by the No Child Left Behind Act of 2001, Title II, Part B - Mathematics and Science Partnerships and the General Appropriations Act, Article III, Rider 40, 80th Texas Legislature, 2007.

Eligible Applicants. The TRC is requesting applications from partnerships that must include an engineering, mathematics, or science department of an institution of higher education (IHE) and a high-need local educational agency (LEA). They may also include another engineering, mathematics, science, or teacher training department of an IHE; additional LEAs, public charter schools, public or private elementary schools or secondary schools, or a consortium of such schools; a business; or a nonprofit or for-profit organization of demonstrated effectiveness in improving the quality of mathematics and science teachers. Applicants must be an existing program with an established track record of successful recruiting, training, placing and mentoring career-change teachers into high need school districts.

Description. The purpose of this notice is to solicit applications from eligible applicants to expand existing programs that recruit professionals with math, science, or technology degrees to become teachers in Texas schools. Program activities shall support the career-change teacher from program initiation through obtaining appropriate teaching certification and continued mentoring to endure ongoing success in the classroom.

Dates of Project. Applicants should plan for a starting date of no earlier than September 1, 2008, and an ending date of no later than July 31, 2009.

Project Amounts. Approximately $1,783,678 in funding is available for the Mid-Career Teacher Recruitment Program for the 2008-2009 grant period. Funding of up to $1,500,000 will be provided for one project. Remaining monies will go to support one to three planning grants.

Selection Criteria. Applications will be selected based on the ability of each applicant to carry out all requirements contained in the Request for Applications (RFA). Reviewers will evaluate applications based on the overall quality and validity of the proposed grant programs and the extent to which the applications address the primary objectives and intent of the project. Applications must address each requirement as specified in the RFA to be considered for funding. The Texas Regional Collaboratives (TRC) reserves the right to select from the highest-ranking applications those that address all requirements in the RFA.

The TRC is not obligated to approve an application, provide funds, or endorse any application submitted in response to this RFA. This RFA does not commit TRC to pay any costs before an application is approved. The issuance of this RFA does not obligate TRC to award a grant or pay any costs incurred in preparing a response.

Further Information. For clarifying information about the RFA, please visit the TRC website at www.thetrc.org or contact Amy Werst at (512) 471-7450.

Deadline for Receipt of Applications. Applications must be received in the TRC by 4:30 p.m. (Central Time), Monday, August 18, 2008 to be eligible to be considered for funding.

TRD-200803454
James P. Barufaldi
Director, Center for Science and Mathematics Education
The University of Texas System
Filed: July 3, 2008

♦ ♦ ♦

Workforce Solutions Brazos Valley Board

Notice of Release of Request for Proposal for Marketing/Advertising/Public Relations Services

On July 7, 2008 Workforce Solutions Brazos Valley Board (WSBVB) will release a Request for Proposal (RFP) for marketing/advertising/public relations services and products for the education of the public and the establishment of a recognizable identity in regards to WSBVB and its programs in the following counties: Brazos, Burleson, Grimes, Leon, Madison, Robertson, and Washington. The Board is seeking a single contractor qualified and experienced in providing a range of marketing services. The complete scope of required services and the proposal requirements are contained in the RFP which may be viewed and downloaded at www.bvjobs.org.

A bidder's conference will be held at the office of Workforce Solutions Brazos Valley Board, 3991 East 29th Street, Bryan, Texas 77802 on July 16, 2008 at 10:00 a.m. CST. Bidders may submit questions by email to pbuck@bvcog.org up until the Bidders conference. All questions and answers will be posted on www.bvjobs.org by July 21, 2008.

Due Date: An original and five (5) copies of a written proposal are due to the Board's offices no later than Thursday, August 7, 2008 at 4:00 p.m. CST. Faxed or email proposals are not acceptable. Proposals received after the indicated due date and time **regardless of delivery method** will not be accepted or considered for award.

Proposals may be hand delivered to:

ATTENTION: MARKETING SERVICES PROPOSAL

Trish Buck, Program Manager

Workforce Solutions Brazos Valley Board

3991 East 29th St.

Bryan, Texas 77802

Proposals may be mailed to:

ATTENTION: MARKETING SERVICES PROPOSAL

Trish Buck, Program Manager

Workforce Solutions Brazos Valley Board

P.O. Drawer 4128

Bryan, Texas 77805

Email address for questions only: pbuck@bvcog.org

Proposals received after the deadline will not be considered. WSBV accepts no responsibility for late proposals.

TRD-200803453
Tom Wilkinson
Executive Director
Workforce Solutions Brazos Valley Board
Filed: July 2, 2008

How to Use the Texas Register

Information Available: The 14 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules- sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Transferred Rules- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Review of Agency Rules - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 30 (2005) is cited as follows: 30 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "30 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 30 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online through the Internet. The address is: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the Internet. For website subscription information, call the Texas Register at (800) 226-7199.

Texas Administrative Code

The ***Texas Administrative Code (TAC***) is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac. The following companies also provide complete copies of the TAC: Lexis-Nexis (1-800-356-6548), and West Publishing Company (1-800-328-9352).

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Table of TAC Titles Affected***. The table is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register*** (January 21, April 15, July 8, and October 7, 2005). If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with one or more ***Texas Register*** page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
Part I. Texas Department of Human Services
40 TAC §3.704.....950, 1820

The ***Table of TAC Titles Affected*** is cumulative for each volume of the ***Texas Register*** (calendar year).